LFG Benefits

COMPLIANCE SERVICES PORTFOLIO

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LFG BENEFITS

Sample Documents

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2026 Open Enrollment Checklist

To prepare for open enrollment, employers that sponsor health plans should be aware of compliance changes affecting the design and administration of their plans for plan years beginning on or after Jan. 1, 2026. These changes include limits adjusted for inflation each year, such as the Affordable Care Act's (ACA) affordability percentage and cost-sharing limits for high deductible health plans (HDHPs). Employers should review their health plan's design to confirm that it has been updated, as necessary, for these changes.

In addition, any changes to a health plan's benefits for the 2026 plan year should be communicated to plan participants through an updated Summary Plan Description (SPD) or a Summary of Material Modifications (SMM).

Health plan sponsors should also confirm that their open enrollment materials contain certain required participant notices, such as the summary of benefits and coverage (SBC), when applicable. Some participant notices must also be provided annually or upon initial enrollment. Employers should consider including these notices in their open enrollment materials to minimize costs and streamline administration.

LINKS AND RESOURCES

- Revenue Procedure 2025-19, which includes the inflation-adjusted limits for health savings accounts (HSAs) and HDHPs for 2026
- Revenue Procedure 2025-25, which includes the inflation-adjusted affordability percentage for applicable large employers (ALEs) for 2026
- Model notices for group health plans, including the Women's Health and Cancer Rights Act (WHCRA) notice
- Model COBRA notices for group health plans

Plan Design Issues

- ALEs should confirm that one of their health plan options will satisfy the ACA's affordability standard for the 2026 plan year.
- Employers with HDHPs should confirm that their plan's deductible and out-of-pocket maximum comply with the 2026 limits.
- Employers should communicate plan design changes to employees as part of the open enrollment process.

Notices to Include

- SBC
- Annual Children's Health Insurance Program (CHIP) notice
- Medicare Part D creditable coverage notice
- WHCRA notice
- Wellness program notices

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COMPLIANCE OVERVIEW

PLAN DESIGN CHANGES

ACA Affordability Standard

The ACA requires ALEs to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or risk paying a penalty to the IRS. This employer mandate is also known as the "pay-or-play" rules. An ALE is an employer with at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year.

An ALE's health coverage is considered affordable if the employee's required contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as adjusted) of the employee's household income for the taxable year. For plan years beginning in 2025, the adjusted affordability percentage is 9.02%. On July 18, 2025, the IRS announced that the affordability percentage will increase to **9.96% for plan years beginning in 2026.** This is a significant increase from the affordability percentage for 2025 and the highest this percentage has ever been. As a result, employers may be able to increase employees' health coverage contributions for 2026 while still meeting the adjusted affordability percentage.

ALEs should take the following step for the 2026 plan year:

- Confirm that at least one of the health plans offered to full-time employees satisfies the ACA's affordability standard (9.96%). Because an employer generally will not know an employee's household income, the IRS has provided three optional safe harbors that ALEs may use to determine affordability based on information that is available to them: the Form W-2 safe harbor, the rate-of-pay safe harbor and the federal poverty line safe harbor.

Out-of-Pocket Maximum

The ACA requires non-grandfathered health plans and health insurance issuers to comply with annual limits on total enrollee cost sharing for essential health benefits (EHB). This type of cost-sharing limit is commonly referred to as an out-of-pocket maximum (OOPM). The OOPMs for EHB for plan years beginning on or after Jan. 1, 2026, are **$10,600** for self-only coverage and **$21,200** for family coverage.

The ACA's OOPM for self-only coverage applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. This requires health plans and issuers to embed an individual OOPM in family coverage if the family OOPM is greater than the ACA's OOPM for self-only coverage ($10,600 for 2026 plan years).

Also, to be compatible with HSA contributions, HDHPs must comply with lower limits on OOPMs.

With these requirements in mind, employers should take the following steps:

- Review the health plan's OOPMs to ensure they comply with the ACA's limits for the 2026 plan year;
- Determine if the health plan's OOPM for family coverage is greater than the ACA's OOPM for self-only coverage ($10,600 for 2026 plan years). If it is greater, make sure the health plan embeds an individual OOPM for family coverage that is not more than $10,600; and
- If the health plan is an HDHP, confirm that it complies with the lower limits on OOPMs. For the 2026 plan year, the OOPMs for HDHPs are $8,500 for self-only coverage and $17,000 for family coverage.

Preventive Care Benefits

The ACA requires non-grandfathered health plans and issuers to cover a set of recommended preventive services without imposing cost-sharing requirements, such as deductibles, copayments or coinsurance, when in-network providers provide the services. The recommended preventive care services covered by these requirements are:

- Evidence-based items or services with an A or B rating in recommendations of the U.S. Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults recommended by the Advisory Committee on Immunization Practices;
- Evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and
- Other evidence-informed preventive care and screenings in HRSA-supported guidelines for women.

Health plans and issuers are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. In general, coverage must be provided for a newly recommended preventive health service or item for plan years beginning on or after the one-year anniversary of when the recommendation was issued. For example, for plan years beginning after Dec. 30, 2025, health plans and issuers must expand their first-dollar coverage for preventive care for women to include **additional breast cancer imaging or testing** that may be required to complete the initial mammography screening process. In addition, health plans and issuers must cover **patient navigation services** for breast and cervical cancer screening without cost sharing.

Before the beginning of the 2026 plan year, employers should take the following step:

- Confirm the health plan covers the latest recommended preventive care services without imposing any cost sharing when the care is provided by in-network providers.

Health FSA Contributions

The ACA imposes a dollar limit on employees' pre-tax contributions to a health flexible spending account (FSA). This limit is indexed each year for cost-of-living adjustments. An employer may set their own dollar limit on employees' contributions to a health FSA as long as the employer's limit does not exceed the ACA's maximum limit in effect for the plan year. For plan years beginning in 2025, the health FSA limit is $3,300. For plan years beginning in 2026, the health FSA limit increases to **$3,400.** Moving forward, employers with health FSAs should take these steps:

Confirm that employees will not be allowed to make pre-tax contributions in excess of $3,400 for plan years beginning in 2026; and

Communicate the health FSA limit to employees as part of the open enrollment process.

HDHP and HSA Limits

The IRS limits for HSA contributions and HDHP cost sharing (minimum deductible and OOPM) increase for 2026. The HSA contribution limits will increase effective Jan. 1, 2026, while the HDHP cost-sharing limits will increase effective for plan years beginning on or after Jan. 1, 2026. Looking ahead, employers should take these steps:

- Check whether HDHP cost-sharing limits need to be adjusted for the 2026 limits; and
- Communicate HSA contribution limits for 2026 to employees as part of the enrollment process.

The following table contains the HDHP and HSA limits for 2026 compared to 2025. It also includes the catch-up contribution limit that applies to HSA-eligible individuals age 55 and older, which is not adjusted for inflation and stays the same from year to year.

Type of Limit		2025	2026	Change
HSA Contribution Limits	Self-only	$4,300	$4,400	**Up $100**
	Family	$8,550	$8,750	**Up $200**
HSA Catch-up Contributions	Age 55 and older	$1,000	$1,000	**No change**
HDHP Minimum Deductibles	Self-only	$1,650	$1,700	**Up $50**
	Family	$3,300	$3,400	**Up $100**
HDHP OOPM *(deductibles, copayments and other amounts but not premiums)*	Self-only	$8,300	$8,500	**Up $200**
	Family	$16,600	$17,000	**Up $400**

HDHPs: Permanent Extension of Telehealth Option

To be eligible for HSA contributions, an individual must be covered under an HDHP and have no other impermissible coverage. Historically, individuals who were covered by telehealth programs that provided free or reduced-cost benefits before the HDHP deductible was satisfied were not eligible for HSA contributions.

A pandemic-related relief measure temporarily allowed HDHPs to waive the deductible for telehealth services without impacting HSA eligibility. This relief expired at the end of the 2024 plan year. However, the One Big Beautiful Bill Act **permanently extends the ability of HDHPs to provide benefits for telehealth and other remote care services before plan deductibles have been met without jeopardizing HSA eligibility.** Due to the permanent extension, HDHPs may waive the deductible for any telehealth or other remote care services for plan years beginning in 2025 and beyond without causing participants to lose HSA eligibility. This provision is optional; HDHPs can apply any telehealth services, other than preventive care, toward the deductible.

Due to this change, employers with HDHPs should take these steps:

- Determine whether the HDHPs will waive the deductible for telehealth services for the plan year beginning in 2026; and
- Notify plan participants of any cost-sharing changes for telehealth services through an updated SPD or SMM.

EBHRA Limit

An excepted benefit health reimbursement arrangement (EBHRA) is an employer-funded health care account that reimburses employees for their eligible medical expenses on a tax-free basis. Employers can use EBHRAs to supplement their traditional health plan coverage and help employees with their out-of-pocket medical expenses, including deductible, copayment and coinsurance amounts. Employers of all sizes may offer EBHRAs. Although an employer must offer a traditional health plan, employees are not required to enroll in the employer's group coverage (or any other type of coverage) to be eligible for the EBHRA.

Only employers can contribute to HRAs, including EBHRAs. EBHRAs are subject to a maximum amount that may be made newly available for the plan year. This maximum amount is adjusted annually for inflation. For 2025 plan years, the contribution limit is $2,150. This limit increases to **$2,200** for plan years beginning in 2026.

Employers that sponsor EBHRAs should take the following steps:

- Decide how much will be contributed to the EBHRA for eligible employees for the 2026 plan year, up to a maximum of $2,200; and
- Communicate the EBHRA's annual benefit amount to employees as part of the open enrollment process.

Wellness Programs—Surcharges/Rewards

Health plans that impose a surcharge (or provide a reward) based on a health-related standard (e.g., not using tobacco or meeting a specific exercise target) must comply with nondiscrimination requirements under the Health Insurance Portability and Accountability Act (HIPAA). Among other requirements, health-contingent wellness programs must provide a reasonable alternative standard for qualifying for the full reward (or avoiding the surcharge) and must disclose the alternative standard in all plan materials describing the surcharge or reward. Numerous class-action lawsuits have recently been filed against employers alleging that health plan premium surcharges related to tobacco use violate HIPAA's nondiscrimination requirements. Given this increased scrutiny, to prepare for the 2026 plan year, employers should take the following steps:

- Decide whether to impose a surcharge (or provide a reward) based on any health-related standard; and
- If a surcharge is imposed (or a reward offered), ensure it is provided through a wellness program that satisfies HIPAA's nondiscrimination requirements, including explaining to participants that a reasonable alternative standard is available for avoiding the surcharge (or qualifying for the reward).

Mental Health Parity—Required Comparative Analysis for NQTLs

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity between a health plan's medical/surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. These parity requirements apply to financial requirements and treatment limits for MH/SUD benefits. In addition, any nonquantitative treatment limitations (NQTLs) placed on MH/SUD benefits must comply with MHPAEA's parity requirements. For example, NQTLs include prior authorization, step therapy protocols, network adequacy and medical necessity criteria.

MHPAEA requires health plans and issuers to conduct comparative analyses of the NQTLs used for medical/surgical benefits compared to MH/SUD benefits. This analysis must contain a detailed, written and reasoned explanation of the specific plan terms and practices at issue and include the basis for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA. Plans and issuers must make their comparative analyses available to specific federal agencies or applicable state authorities upon request. In 2024, federal agencies released a final rule under MHPAEA that would have imposed

stricter standards for comparative analyses for the plan year beginning in 2026. However, enforcement of this final rule has been put on hold by the Trump administration. Although the final rule's requirements are not being enforced, MHPAEA's statutory requirement to conduct comparative analyses remains in effect.

Considering this information, employers should take the following step:

- Reach out to the health plan's issuer or third-party administrator (TPA) to confirm that comparative analyses of NQTLs will be updated, if necessary, for the plan year beginning in 2026.

Open Enrollment Notices

Employers that sponsor health plans should provide certain benefits notices in connection with their plans' open enrollment periods. Some of these notices must be provided at open enrollment time, such as the SBC. Other notices, such as the WHCRA notice, must be distributed annually. Although these annual notices may be provided at different times throughout the year, employers often choose to include them in their open enrollment materials for administrative convenience.

In addition, employers should review their open enrollment materials to confirm that they accurately reflect the terms and cost of coverage. In general, any plan design changes for 2026 should be communicated to plan participants either through an updated SPD or an SMM.

Summary of Benefits and Coverage

The ACA requires health plans and health insurance issuers to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. Federal agencies have provided a template for the SBC, which health plans and issuers are required to use. To comply with the SBC requirements, employers should include an updated SBC with open enrollment materials.

Take note that the plan administrator is responsible for providing the SBC for self-funded plans. For insured plans, the issuer usually prepares the SBC. If the issuer prepares the SBC, an employer is not required to also prepare an SBC for the health plan, although they may need to distribute the SBC prepared by the issuer.

Medicare Part D Notices

Employers that provide prescription drug coverage to individuals who are eligible for Medicare Part D must inform these individuals whether their prescription drug coverage is creditable, meaning that the employer's prescription drug coverage is at least as good as Medicare Part D coverage. There is no penalty or fee for employers that offer prescription drug coverage that is non-creditable. Non-creditable prescription drug coverage can still be a valuable benefit for employees. However, individuals need to know whether their prescription drug coverage is creditable or non-creditable. If the coverage is non-creditable, and Medicare-eligible individuals fail to enroll in Part D during their initial enrollment period, they can be subject to a higher Part D premium if they enroll in Part D at a later date.

The notice generally must be provided at various times, including when an individual enrolls in the plan and each year before **Oct. 15** (when the Medicare annual open enrollment period begins). Model notices are available on the Centers for Medicare and Medicaid Services' website.

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Annual CHIP Notices

Health plans covering residents in a state that provides a premium subsidy to low-income children and their families to help pay for employer-sponsored coverage must send an annual CHIP notice about the available assistance to all employees residing in that state. The U.S. Department of Labor (DOL) has provided a model notice. Employers should confirm they are using the most recent model notice, as the DOL updates it regularly.

Initial COBRA Notices

COBRA applies to health plans sponsored by employers with 20 or more employees. Health plan administrators must provide an initial COBRA notice to new participants and certain dependents within **90 days** after plan coverage begins. The initial COBRA notice may be incorporated into the plan's SPD. A model initial COBRA notice is available from the DOL.

SPDs

Plan administrators must provide an SPD to new participants within **90 days** after plan coverage begins. Any changes made to the plan should be reflected in an updated SPD booklet or described to participants through an SMM. Also, an updated SPD must be furnished every five years if changes are made to SPD information or the plan is amended. Otherwise, a new SPD must be provided every 10 years.

Notices of Patient Protections

Under the ACA, health plans and issuers that require the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for such care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If an employer's plan is subject to this notice requirement, they should confirm that it is included in the plan's open enrollment materials. This notice may be included in the plan's SPD or benefit summary provided by the issuer or TPA. Model language is available from the DOL.

Grandfathered Plan Notices

If an employer has a grandfathered plan, it should include information about the plan's grandfathered status in plan materials describing the coverage under the plan, such as SPDs and open enrollment materials. Model language is available from the DOL.

Notices of HIPAA Special Enrollment Rights

An employer's health plan must notify each eligible employee of their special enrollment rights under HIPAA at or before enrollment. This notice may be included in the plan's SPD or benefit summary provided by the issuer or TPA.

HIPAA Privacy Notices

The HIPAA Privacy Rule requires covered entities (including health plans and issuers) to provide a Notice of Privacy Practices (or Privacy Notice) to each individual who is the subject of protected health information (PHI). Health plans are required to send the Privacy Notice at certain times, including to new enrollees at the time of enrollment. Also, at least once every three years, health plans must either redistribute the Privacy Notice or notify participants that the Privacy Notice is available and explain how to obtain a copy.

Self-insured health plans must maintain and provide their own Privacy Notices. However, special rules apply for fully insured plans, where the issuer, not the plan itself, is primarily responsible for the Privacy Notice.

Special Rules for Fully Insured Plans

The sponsor of a fully insured health plan has limited responsibilities with respect to the Privacy Notice, including the following:

If the sponsor of a fully insured plan has access to PHI for plan administrative functions, they are required to maintain a Privacy Notice and provide the notice upon request; and

If the sponsor of a fully insured plan does not have access to PHI for plan administrative functions, they are not required to maintain or provide a Privacy Notice.

A plan sponsor's access to enrollment information, summary health information and PHI that is released pursuant to a HIPAA authorization does not qualify as having access to PHI for plan administration purposes.

Model Privacy Notices are available through the U.S. Department of Health and Human Services.

WHCRA Notices

Health plans and issuers must provide a notice of participants' rights to mastectomy-related benefits under the WHCRA at the time of enrollment and on an annual basis. The DOL's compliance assistance guide includes model language for this disclosure.

SARs

Plan administrators required to file Form 5500 must provide participants with a narrative summary of the information in Form 5500, called a summary annual report (SAR). Health plans that are unfunded (that is, benefits are payable from the employer's general assets and not through an insurance policy or trust) are not subject to the SAR requirement. The plan administrator generally must provide the SAR within nine months of the close of the plan year. If an extension of time to file Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period. A model notice is available from the DOL.

Wellness Program Notices

Health plans that include wellness programs may be required to provide certain notices regarding the program's design. As a general rule, these notices should be provided when the wellness program is communicated to employees and before employees provide any health-related information or undergo medical examinations. These notices are required in the following situations:

- **HIPAA Wellness Program Notice**—HIPAA imposes a notice requirement on health-contingent wellness programs offered under health plans. Health-contingent wellness plans require individuals to satisfy standards related to health factors (e.g., not smoking) to obtain rewards or avoid surcharges. The notice must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) and be included in all plan materials describing the terms of a health-contingent wellness program. The DOL's compliance assistance guide includes a model notice that can be used to satisfy this requirement.

- **Americans with Disabilities Act (ADA) Wellness Program Notice**—Employers with 15 or more employees are subject to the ADA. Wellness programs that include health-related questions or medical exams must comply with the ADA's requirements, including an employee notice requirement. Employers must give participating employees a notice that tells them what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, as well as include the limits on disclosure and the way information will be kept confidential. The U.S. Equal Employment Opportunity Commission has provided a sample notice to help employers comply with this ADA requirement.

ICHRA Notices

Employers may use individual coverage health reimbursement arrangements (ICHRAs) to reimburse their eligible employees for insurance policies purchased in the individual market or for Medicare premiums. Employers with ICHRAs must provide a notice to eligible participants about the ICHRA and its interaction with the ACA's premium tax credit. In general, this notice must be provided at least **90 days** before the beginning of each plan year. Employers may provide this notice at open enrollment time if it is at least 90 days prior to the beginning of the plan year. A model notice is available for employers to use to satisfy this notice requirement.

COMPLIANCE OVERVIEW

ERISA Compliance FAQs: Enforcement

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for employee benefit plans maintained by private-sector employers. ERISA includes requirements for both retirement plans (for example, 401(k) plans) and welfare benefit plans (for example, group health plans). ERISA has been amended many times over the years, expanding the protections available to welfare benefit plan participants and beneficiaries.

The Department of Labor (DOL), through its Employee Benefits Security Administration (EBSA), enforces most of ERISA's provisions. Violating ERISA can have serious and costly consequences for employers that sponsor welfare benefit plans, either through DOL enforcement actions and penalty assessments or through participant lawsuits.

This Compliance Overview includes a set of frequently asked questions (FAQs) to help employers understand how ERISA's requirements for welfare benefit plans are enforced.

LINKS AND RESOURCES

Department of Labor resources:

- Webpage on ERISA enforcement
- 2024 Fiscal Year Audit Summary (and archive for prior fiscal years)
- Webpage on Correction Programs (Voluntary Fiduciary Correction Program and Delinquent Filer Voluntary Compliance Program)

Health Plan Investigations

- The DOL audits employee benefit plans for compliance with ERISA, the Affordable Care Act (ACA) and other federal laws.
- Participants may also sue their welfare benefit plans for violations.
- Noncompliance may result in civil penalties or criminal charges.

Common Violations

- Failures to file complete/correct Form 5500
- Failures to respond to participant requests for information
- Breaches of fiduciary duties

COMPLIANCE OVERVIEW

How Does the DOL Enforce ERISA?

The DOL has broad authority to investigate or audit an employee benefit plan's compliance with ERISA. The DOL's EBSA division handles audits of employee benefit plans. To perform these audits, EBSA employs investigators working out of field offices, many of whom are lawyers or CPAs or who have advanced degrees in business or finance.

DOL audits often focus on violations of ERISA's fiduciary obligations and reporting and disclosure requirements. The DOL may also investigate whether an employee benefit plan complies with ERISA's protections for plan participants. The DOL also uses its investigative authority to enforce compliance with the Affordable Care Act (ACA).

> ***Enforcement Statistics***: During the 2024 fiscal year, EBSA closed 729 civil investigations. Of these, 71% resulted in monetary results for plans or other corrective action.
>
> In addition, EBSA referred 53 cases for civil litigation and closed 177 criminal investigations. EBSA's criminal investigations led to the indictment of 68 individuals—including plan officials, corporate officers and service providers—for offenses related to employee benefit plans.

What Are the Possible Consequences of a DOL Investigation?

Being selected for a DOL audit can have serious consequences for an employer. According to a DOL audit report for the 2024 fiscal year, 71% of civil investigations resulted in penalties or required other corrective action, such as paying amounts to restore losses, disgorging profits and ensuring claims were properly processed and paid. In addition, a DOL audit may negatively affect an employer's normal business operations because the audit process can be both stressful and time-consuming.

The DOL has the authority to assess civil penalties for many different types of ERISA violations. Common penalty assessments involve the following:

Form 5500 violations (for example, not filing a Form 5500 when required or filing an incomplete Form 5500)	The DOL has the authority under ERISA to assess penalties of up to $2,739 per day for each day an administrator fails or refuses to file a complete Form 5500. This maximum penalty amount is adjusted each year for inflation. The penalties may be waived if the noncompliance was due to reasonable cause.
Failing to respond to participants' requests for plan information	If a plan administrator fails to respond to a participant's request for plan documents (for example, the latest summary plan description) within 30 days, the plan administrator may be charged up to $110 per day from the date of the failure or refusal to provide the information.
Breaches of fiduciary duty	For fiduciary duty breaches, the DOL will assess a civil penalty against the fiduciary in an amount equal to 20 percent of the applicable recovery amount. If a fiduciary breach has been found, the penalty is mandatory. In general, the penalty is assessed after payment of the applicable recovery amount pursuant to a settlement agreement with the DOL.

In addition, a DOL audit may lead to a **criminal investigation** of a plan sponsor, fiduciary or service provider if criminal activity (such as embezzlement, kickbacks and false statements) is discovered during an audit. Whether a matter is referred for criminal prosecution depends on a number of factors, including:

The egregiousness and magnitude of the violation;

The desirability and likelihood of incarceration both as a deterrent and as a punishment; and

Whether the case involves a person who violated ERISA's requirements before.

Why Does the DOL Select Certain Health Plans for Audit?

A DOL audit can be triggered for a variety of reasons. In most cases, the DOL investigator will not disclose to an employer why its health plan was selected for audit. However, there are some common audit triggers that an employer should keep in mind.

Common triggers for a DOL audit include:

Participant complaints to the DOL about potential ERISA violations. According to the DOL, when it becomes aware of repeated complaints with respect to a particular plan, employer or service provider, or when there is information indicating a suspected fiduciary breach, the matter is referred for investigation.

Answers on the plan's Form 5500. For example, if a plan's Form 5500 is incomplete, or if inconsistent information is reported from year to year, the DOL may investigate the issue further.

The DOL's **national enforcement priorities or projects**, which target the DOL's resources on certain issues. For example, the DOL's Health Enforcement Initiatives project focuses on making sure health plans and health insurance issuers comply with group health plan mandates, including mental health parity requirements.

How Can an Employer Minimize Its Risk of Being Audited By the DOL?

As a practical matter, an employer has little control over whether it will be audited by the DOL. However, an employer can take the following steps to help minimize its exposure to a DOL audit:

Respond to participants' benefit questions and requests for information on a timely basis;

File Form 5500 on time and make sure it is complete and accurate;

Distribute participant notices required by law (for example, the summary of benefits and coverage) by the deadline; and

Make timely updates to plan documents and summary plan descriptions (SPDs) to reflect legal and design changes.

How Do Employers Know If They Are Selected by the DOL For an Audit?

When the DOL selects an employer's health plan for audit, the DOL will send out an investigatory letter. This letter serves to notify the employer that a DOL investigation will take place. Investigations can be in the form of a "limited review" or a full-scale investigation.

Generally, the initial letter from the DOL will include a request for a list of plan-related documents. Employers that receive audit letters may be surprised and overwhelmed by the number of documents requested by the DOL auditor. Although employers generally have no way of knowing whether they will be selected for an audit, it is important for them to

maintain employee benefit documents in an organized fashion so they can respond to a DOL audit request in the event this occurs.

Typically, the audit letter will request that the documents be provided by a specified date. Inadequate or late responses could trigger additional document requests, interviews, on-site visits and even DOL enforcement actions.

How Can Employers Prepare for a DOL Audit?

Just because an employer has been selected for an audit does not mean that the employer has violated an employee benefits law. Even an employer in compliance can encounter an unexpected audit. A DOL audit is not a simple process and being prepared can potentially save an employer a large amount of money, time and stress.

The best way to prepare for a DOL audit is to remain in compliance with the law and establish a recordkeeping system for maintaining all of the important documents relating to your employee benefit plans. Retaining complete and accurate records will help move along the audit process and provide an accurate picture of an employer's benefit package. As a general rule, these records should be retained for **seven years**.

Employers should consider reviewing their health plans for compliance now, before they are selected for audit. It is important for employers to get their health plans' paperwork in order as part of this process. Employers may want to designate one location for maintaining records relating to their health plans, such as plan documents and insurance contracts, SPDs and notices required under the ACA and other federal laws (for example, the Women's Health and Cancer Rights Act). Even though a compliance review will require some time and effort now, it will likely pay off in the future in the event the employer is selected for a DOL audit.

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CHECKLIST | COMPLYING WITH THE FMLA

Presented by LFG Benefits

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees of covered employers with unpaid, job-protected leave for certain family and medical reasons. In addition to providing eligible employees with leave for qualifying reasons, covered employers must maintain employees' health benefits during leave and restore employees to their same (or equivalent) jobs after leave.

This checklist outlines key steps for employers to comply with the FMLA. Keep in mind that complying with the FMLA may involve additional steps depending on the facts of a specific situation. Also, many states (and some localities) have their own family and medical leave laws that provide broader leave protections to employees. Employers will need to comply with the FMLA and any applicable state and local leave laws.

General Requirements

Covered Employers	Yes	No
Is your company subject to the FMLA? Select "yes" if your company is any of the following: • A private-sector employer with **50 or more employees** in 20 or more workweeks in the current or preceding calendar year; • A public agency (including state and local governments and governmental agencies) of any size; or • A public or private school (elementary or secondary) of any size.	☐	☐

FMLA Requirements	Complete
Display the FMLA poster in plain view where employees and applicants can readily see it. A model poster is available from the U.S. Department of Labor (DOL). Employers may use the model poster, create their own poster or use another format, as long as it provides all of the information in the model poster and meets all of the posting requirements.	☐
If your company has employees eligible for FMLA leave, provide employees with a general notice about the FMLA in the employee handbook or other written materials about leave and benefits. Employers can use the text from the DOL's model poster for this notice or another format as long as it provides all of the information in the model poster.	☐
Create and maintain records related to FMLA compliance (e.g., copies of FMLA notices and dates of FMLA leave). These records must be kept for at least three years.	☐

FMLA Administration	Complete
Select the 12-month period used for calculating FMLA leave (or the "leave year") and confirm that it is accurately described in employee communications. An employer's options for the leave year are: • The calendar year (Jan. 1 through Dec. 31) • Any fixed 12-month period, such as a fiscal year or a leave year beginning on the first day of an employee's employment • A 12-month period measured forward from the first date an employee takes FMLA leave • A rolling 12-month period measured backward from the date an employee uses FMLA leave	☐
Implement a method for tracking employees' use of FMLA leave throughout the year, including leave taken on an intermittent or reduced schedule basis.	☐
Train managers on FMLA compliance, including how to identify leave requests that may be for FMLA qualifying reasons and the law's prohibitions on interference and retaliation.	☐
Download and use the DOL's model forms for administering FMLA leaves or create your own versions of these forms. The DOL's model FMLA forms are available here	☐
Determine how employees will pay health plan premiums during unpaid FMLA leave and communicate this method to employees taking leave.	☐
Review how taking FMLA leave may relate to other types of employee absences, including employer-provided paid time off, short-term disability, workers' compensation and local paid leave law requirements, and run leaves concurrently when possible.	☐

Administering FMLA Leave

Employee name	
Date of leave request	
Dates of anticipated leave	

Employee Eligibility	Yes	No
Is the employee eligible for FMLA leave? To be eligible for FMLA leave, an employee must satisfy ALL of the following criteria: • The employee works for an employer covered by the FMLA;	☐	☐

Employee Eligibility	Yes	No
• The employee has worked for the employer for at least 12 months as of the date leave is to start (it does not need to be consecutive); • The employee has at least 1,250 hours of service for the employer during the 12-month period before the leave is to start; and • The employee works at a location where the employer has at least 50 employees within 75 miles of that worksite.		
Is the employee's leave for a qualifying reason? Is the leave for one of the following FMLA-qualifying reasons? • The birth of a child and to bond with the newborn child within one year of birth • The placement of a child for adoption or foster care and to bond with the newly-placed child within one year of placement • A serious health condition that makes the employee unable to perform the functions of their job • To care for the employee's spouse, child or parent who has a serious health condition • Any qualifying exigency arising out of the fact that the employee's spouse, child or parent is a military member on covered active duty (or call to covered active duty status) • To care for a covered servicemember with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the servicemember	☐	☐
If the employee has already used FMLA leave this year, does the employee still have FMLA leave available? Eligible employees are entitled to take up to 12 weeks of FMLA leave during a 12-month period (26 weeks to care for a covered servicemember).	☐	☐

Leave Process	Complete
Provide the Notice of Eligibility and Rights & Responsibilities within five business days of the employee's request for leave, unless there are extenuating circumstances. The DOL has a model notice (Form WH-381, Notice of Eligibility and Rights & Responsibilities) that employers may use for this notice requirement.	☐
If a medical certification is required for the requested leave, give the appropriate form to the employee and provide the employee with 15 calendar days to return the form An employer may require a medical certification when leave is requested for the employee's own serious health condition or the serious health condition of a family member. Employers can also require certification for military family leave. The DOL has model forms that employers may use for obtaining certifications. An employee requesting leave should be	☐

Leave Process	Complete
informed of this requirement, and the appropriate certification form should be provided with the Notice of Eligibility and Rights & Responsibilities.	
Grant or deny the FMLA leave by providing the Designation Notice on a timely basis This notice must be provided once the employer has enough information to determine if the employee's requested leave qualifies as FMLA leave, as follows: • If a medical certification is not required for the requested leave, provide the Designation Notice within five business days of the leave request • If a medical certification is required, provide the Designation Notice within five business days of when the employee submits a complete and sufficient certification form. The Designation Form can also inform the employee that the certification is incomplete or insufficient and additional information is needed. The DOL has a model Designation Notice (Form WH-382) that employers may use.	☐
During leave, maintain coverage under the group health plan on the same basis as coverage would have been provided if the employee had been continuously employed during the entire leave period During the FMLA leave period, an employee must continue to pay whatever share of group health plan premiums the employee paid prior to FMLA leave. The employer must provide the employee with advance written notice of the terms and conditions under which these payments must be made.	☐
If applicable, the employee must provide a fitness-for-duty certification to show that they can resume work after taking a leave for their own serious health condition. Employers may have a uniform policy requiring all similarly-situated employees who take leave for serious health conditions to provide a fitness-for-duty certification.	☐
Restore the employee to the same job (or an equivalent job) at the end of the leave.	☐

Use this checklist as a guide when reviewing your company's compliance with the FMLA. For assistance, contact LFG Benefits.

DOL AUDIT GUIDE:

Employee Benefit Plans

Presented by **LFG Benefits**

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This guide is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. This guide may not address all compliance issues with federal, state and local laws or identify all possible requests that may be made in connection with an audit. Compliance with all applicable legal requirements is the responsibility of the health plan sponsor. Using the materials in this guide does not guarantee that a plan sponsor will be able to avoid an audit or is in compliance with all applicable requirements. Use this guide as reference but contact legal counsel to discuss compliance requirements.

INTRODUCTION

The Department of Labor (DOL) has broad authority to investigate or audit an employee benefit plan's compliance with the Employee Retirement Income Security Act (ERISA). Audits are performed by the DOL's Employee Benefits Security Administration (EBSA). To perform these audits, EBSA employs investigators working out of field offices, many of whom are lawyers or CPAs or have advanced degrees in business and finance.

DOL audits often focus on violations of ERISA's fiduciary obligations and reporting and disclosure requirements. The DOL may also investigate whether an employee benefit plan complies with ERISA's protections for plan participants, such as the special enrollment rules or mental health parity requirements. The DOL also uses its investigative authority to enforce compliance with the health care reform law, or the Affordable Care Act (ACA).

Being selected for a DOL audit can have **serious consequences** for an employer. According to a DOL audit report for the 2024 fiscal year, 71 percent of civil investigations resulted in penalties or required other corrective action, such as paying amounts to restore losses, disgorging profits and ensuring claims were properly processed and paid. In addition, a DOL audit may negatively affect an employer's normal business operations because the audit process can be both stressful and time-consuming. The best time for an employer to analyze whether it is ready for a DOL audit is **before** the DOL comes knocking.

This Guide is your manual for preparing for a DOL audit of your HEALTH PLAN. This Guide is designed to provide you with an overview of why certain health plans are selected for audit and what you can do to prepare for an audit and reduce your risk of being audited. It also describes what is typically required of an employer during a health plan audit. It includes:

- Suggestions on how to prepare for a DOL audit;
- Tips for responding to a DOL audit letter;
- A list of documents that DOL investigators commonly request during an audit; and
- A list of available resources and sample documents to help you prepare for an audit.

PREPARING FOR (AND AVOIDING) A DOL AUDIT

Because a DOL audit can disrupt an employer's day-to-day business operations and possibly result in penalties (or other corrective action), it is important for employers to know how to prepare for, and potentially avoid, a DOL audit of their health plan.

As a general rule, the best way to prepare for a DOL audit of your health plan is to confirm that your plan complies with all applicable federal laws, such as HIPAA and the ACA. It is also important to have documents showing your compliance and to maintain these documents so they are easy to access in the event of a DOL audit. If an employer takes these steps before being selected for audit, it can reduce its exposure to penalties. It can also make the audit process more manageable and less time-consuming.

It is also important for an employer to understand why the DOL selects certain health plans for audit and take steps to minimize that audit risk.

AUDIT TRIGGERS

A DOL audit can be triggered for a variety of reasons. In most cases, the DOL investigator will not disclose to an employer why its health plan was selected for audit. However, there are some common audit triggers that an employer should keep in mind.

Common triggers for a DOL audit include:

- **Participant complaints** to the DOL about potential ERISA violations. According to the DOL, when it becomes aware of repeated complaints with respect to a particular plan, employer or service provider, or when there is information indicating a suspected fiduciary breach, the matter is referred for investigation.
- Answers on the plan's **Form 5500.** For example, if a plan's Form 5500 is incomplete, or if inconsistent information is reported from year to year, the DOL may investigate the issue further.
- The DOL's **national enforcement** priorities or projects, which target the DOL's resources on certain issues. For example, the DOL's Health Enforcement Initiatives Project focuses on making sure health plans and health insurance issuers comply with federal benefits mandates, including the ACA.

ACA COMPLIANCE OVERVIEW

Electronic Filing of ACA Returns

The Affordable Care Act (ACA) created reporting requirements under Internal Revenue Code (Code) Sections 6055 and 6056. Under these rules, certain employers must provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees.

Under the original rules, any reporting entity that was required to file at least 250 individual statements under Sections 6055 or 6056 had to file electronically. However, in 2023 the IRS released a final rule implementing a law change by the Taxpayer First Act of 2019, which lowers the 250-return threshold for mandatory electronic reporting to 10 returns. **As a result, most reporting entities are now required to complete their ACA reporting electronically.**

This ACA Compliance Overview describes the process for reporting electronically under Sections 6055 and 6056.

LINKS AND RESOURCES

The IRS maintains an AIR Program Main Page for more information on electronic reporting. The IRS has also issued the following guidance:

- Publication 5165—A guide that provides very detailed technical information on standards for software developers & transmitters that facilitate electronic reporting through the AIR Program.
- Publication 5164—A test package that contains general and program specific testing information for use with the ACA Assurance Testing System (AATS).
- Publication 5258—A guide that provides information for issuers, transmitters and software developers on composing and successfully transmitting compliant submissions to the IRS.
- The IRS has designated the **AIR Help Desk** as the first point of contact for electronic filing issues (1-866-937-4130).

Electronic Reporting

Electronic filing is done using the ACA Information Returns (AIR) Program.

The AIR Program is not generally intended to be used by employers that are required to file under Section 6055 or Section 6056.

In most cases, issuers, employers and other reporting entities will use a third-party vendor to file electronically on their behalf. **As a result, these entities will not directly use the AIR Program themselves.**

Important Dates

March 2, 2026

Reporting entities are **no longer required to automatically send** Forms 1095-B and 1095-C to covered individuals unless a form is requested. Reporting entities must provide timely notice of this option by posting a clear and conspicuous notice on their website no later than March 2, 2026. The notice must be retained until Oct. 15, 2026.

March 31, 2026

The deadline for filing 2025 returns with the IRS electronically.

Electronic Reporting Requirement

Under the original ACA reporting rules, any reporting entity that was required to file at least 250 individual statements under Sections 6055 or 6056 had to file electronically, and this requirement applied separately to each type of individual statement. **Beginning in 2024, employers that file at least 10 returns during the calendar year must file their ACA returns electronically, and this threshold applies in the aggregate to certain information returns.** This means that a reporting entity may be required to file fewer than 10 of the applicable Form 1094 and 1095, but still have an electronic filing obligation based on other kinds of information returns filed (e.g., Forms W-2 and 1099).

Currently, electronic filing is done using the AIR Program. The IRS has provided a lot of guidance and information on electronic reporting under Section 6055 and Section 6056 through its AIR Program main page. **However, this guidance is generally very technical and intended for software developers and other entities that plan on providing electronic reporting services.** Nonetheless, it can provide useful information on standards and procedures for returns transmitted through the AIR Program.

AIR Program Overview

In general, the AIR Program is used by:

1) **Software developers** who develop software for creating electronic files for ACA information returns;
2) **Transmitters** who will transmit information returns to the IRS on behalf of reporting entities; and
3) **Issuers who have the capability** to transmit information returns directly to the IRS on their own behalf.

In most cases, issuers, employers and other reporting entities will use a third-party vendor to file electronically with the IRS on their behalf. As a result, these entities will not directly use the AIR Program themselves.

Electronic Reporting Process

The following steps must be completed by entities that submit electronic returns through the AIR Program:

- ☑ **Step One:** Register to use IRS e-Services tools and apply for the ACA Application for Transmitter Control Code (TCC). Reporting entities that are using third-party vendors—and are not transmitting information returns directly to the IRS—should not apply for a TCC.
- ☑ **Step Two:** Pass all applicable test scenarios. **Software developers** are required to annually pass ACA Assurance Testing System (AATS) testing to transmit information returns to the IRS, and those who passed testing for any tax year ending after Dec. 31, 2014, do not need to test for the current tax year. **Transmitters and issuers** must use approved software to perform the communications test, which is only required to be successfully completed once.

Additional details and IRS resources are available on the IRS' AIR Program main page.

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Waiver From Electronic Filing Requirement

A hardship waiver may be requested from the electronic filing requirement by submitting Form 8508, *Application for Waiver from Electronic Filing of Information Returns*, to the IRS. Reporting entities are encouraged to submit Form 8508 at least 45 days before the due date of the returns, **but no later than the due date of the returns**. The IRS does not process waiver requests until Jan. 1 of the calendar year the returns are due.

According to the Form 8508 instructions, a reporting entity's first request for a waiver will be automatically granted. However, if a reporting entity has requested a waiver in the past, they must attach required cost estimates or a written statement justifying their application for a waiver to electronically file. Examples include:

- **Undue financial hardship** in which the cost of filing the information returns exceeds the cost of filing the returns on other media. Two cost estimates comparing the filing of information returns electronically with the cost to file in paper form must be attached.
- Business suffered a **catastrophic event in a federally declared disaster area** that made the business unable to resume operations or made necessary records unavailable.
- **Fire, casualty, or natural disaster** affected the operation of the business.
- Death, serious illness, or unavoidable absence of the individual responsible for filing the information returns affected the operation of the business.
- Business was in its first year of establishment.
- **Foreign entity** who is unable to file electronically due to inability to obtain software, third party provider, or other issues outside of their control.

Reporting entities cannot apply for a waiver for more than one tax year at a time and must reapply at the appropriate time for each year a waiver is required. Any approved waivers should be kept for the reporting entity's records only. A copy of an approved waiver should not be sent to the service center where paper returns are filed.

If a waiver for original returns is approved, any corrections for the same types of returns will be covered under the waiver. However, if original returns are submitted electronically, but the reporting entity wants to submit corrections on paper, a waiver must be approved for the corrections if the reporting entity must file 10 or more corrections.

Without an approved waiver, a reporting entity that is required to file electronically but fails to do so may be subject to a penalty of up to **$340** per return (as adjusted annually) unless it can establish reasonable cause. However, reporting entities can file up to 10 returns on paper. Those returns will not be subject to a penalty for failure to file electronically. The penalty applies separately to original returns and corrected returns.

Filing Extension Requests

Reporting entities can request an **automatic 30-day extension** of time to file by completing Form 8809, *Application for Extension of Time To File Information Returns*, and filing it with the IRS **on or before the due date of the returns**. No signature or explanation is required for the extension. Form 8809 may be submitted on paper or through the FIRE System either as a fill-in form or an electronic file.

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Benefits Toolkit

Employer's Guide to COBRA Administration

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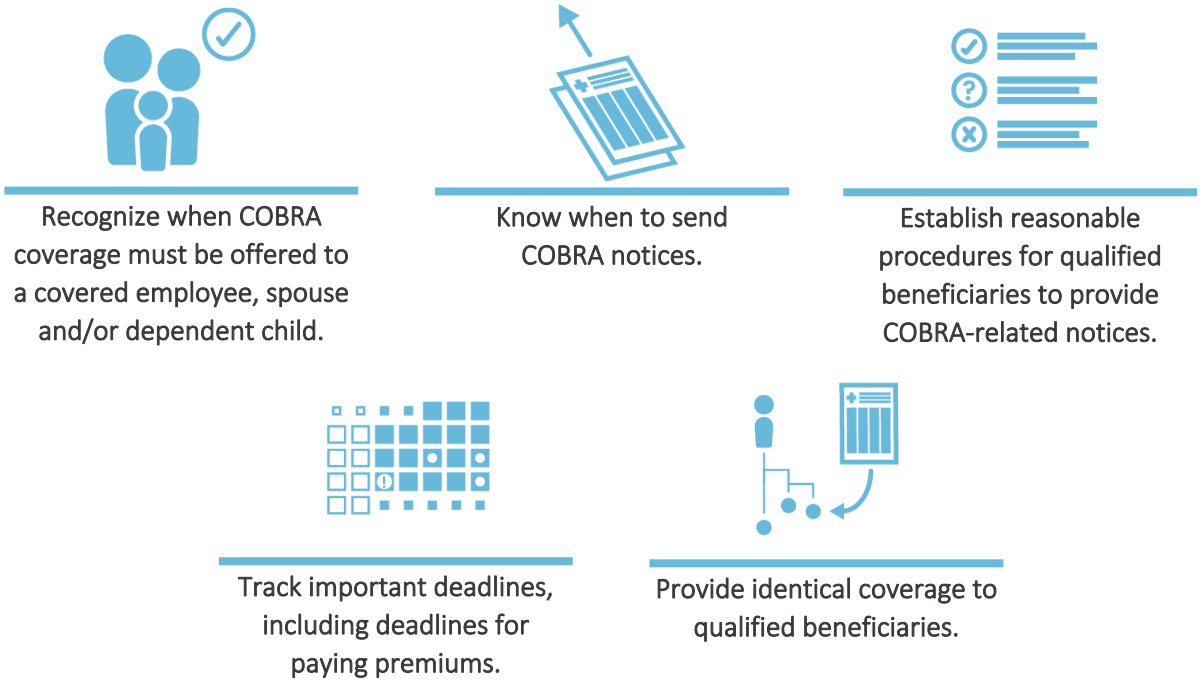
Introduction

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires employers with 20 or more employees to offer continuation coverage to covered employees, spouses and dependent children when their health coverage would otherwise end due to certain events.

Complying with COBRA is not easy. The law's requirements are complex and include several mandatory notices and multiple deadlines to follow and administer. Not only must employers be familiar with COBRA's legal requirements, but they also must ensure they have the necessary procedures in place to administer COBRA coverage properly. Mistakes can easily occur if an employer does not have an effective process in place to administer COBRA coverage and keep track of strict deadlines.

To appropriately administer COBRA coverage, employers must:



This is no small task, but it is one that employers should prioritize because COBRA mistakes can be costly, even if they are unintentional. Due to the complexities of the law and potentially serious consequences for errors, some employers outsource COBRA administration to a third-party vendor. Even when COBRA administration is outsourced, employers will still be responsible for some important aspects of administering COBRA, such as recognizing when COBRA coverage must be offered to a covered employee, spouse or dependent and providing COBRA enrollees with open enrollment opportunities.

This Benefits Toolkit provides a broad overview of COBRA coverage and then outlines the steps to take throughout the administration process. Employers who administer COBRA coverage themselves should periodically review their compliance with COBRA's requirements to avoid potential penalties and lawsuits and control health care spending.

COMPLIANCE OVERVIEW

Voluntary Benefits – ERISA Compliance Exemption

Voluntary benefits are optional benefits that employers may offer to enhance their traditional benefits packages. Offering voluntary benefits allows an employer to include a variety of benefits that are attractive to employees in their benefits package without adding to their organization's costs. While voluntary benefits are typically employee-paid, payments can be automatically deducted from employees' paychecks and remitted to the insurance carrier.

Employers can minimize their compliance obligations by structuring their voluntary benefits to qualify for a safe harbor exemption under the Employee Retirement Income Security Act (ERISA). This exemption is significant because it relieves an employer of ERISA's various compliance requirements for its voluntary benefits, such as distributing a Summary Plan Description (SPD) and filing an annual report (i.e., Form 5500).

The employer's involvement with a voluntary benefit is the key to determining whether it is exempt under ERISA. If an employer endorses the benefit, it will fall outside the safe harbor exemption and may be subject to ERISA. Employers that want to fall under the ERISA exemption should follow the safe harbor rules and ensure they do not take actions that endorse the voluntary benefit.

LINKS AND RESOURCES

- U.S. Department of Labor (DOL) regulations containing the safe harbor exemption for voluntary benefits
- DOL website on ERISA compliance for health plans and benefits

Exemption Requirements

To fall under the safe harbor exemption, a voluntary benefit must satisfy these conditions:

- 100% employee-paid;
- Voluntary employee participation;
- No employer endorsement of the benefit; and
- No consideration paid to the employer from the carrier for offering the benefit.

Common Types

The following are common types of voluntary benefits:

- Life insurance;
- Long-term care insurance;
- Critical illness insurance;
- Disability insurance;
- Dental or vision insurance;
- Hospital indemnity insurance;
- Accident insurance; and
- Legal assistance programs.

ERISA

ERISA sets minimum standards for employee benefit plans maintained by private-sector employers. ERISA exempts only two types of employers from its requirements: governmental and church employers. Through its Employee Benefits Security Administration, the DOL enforces most of ERISA's provisions. Violating ERISA can have serious and costly consequences for employers that sponsor welfare benefit plans, either through DOL enforcement actions and penalty assessments or participant lawsuits.

If an employee benefit is exempt from ERISA, the employer does not have to comply with the requirements outlined below for that benefit. On the other hand, employers that sponsor ERISA plans are generally protected against lawsuits for punitive and other types of damages under state laws with respect to their benefit plans. An ERISA exemption means that these protections do not apply to the employer (or insurance carrier) with respect to that benefit.

Key Compliance Requirements

Under ERISA, employers are generally required to take the following steps with respect to their employee benefit plans:

- Adopt an official plan document that describes the plan's terms and operations;
- Explain the plan's terms and rules to participants through an SPD;
- File an annual report (Form 5500) for the plan unless a filing exemption applies;
- Comply with certain fiduciary standards of conduct with respect to the plan; and
- Establish a claims and appeals process for participants to receive benefits from the plan.

Employee benefit plans that provide medical care may be subject to additional compliance requirements for group health plans, such as COBRA's continuation coverage requirements and HIPAA's privacy and security requirements.

Covered Benefits

Many plans or programs that provide nonretirement benefits to employees are considered employee welfare benefit plans that are subject to ERISA. For example, ERISA generally applies to medical benefits, dental and vision benefits, accident and sickness benefits, life insurance, disability benefits and disease-specific coverage, such as cancer insurance policies. To qualify as an ERISA plan, there must be a plan, fund or program established by the employer for the purpose of providing ERISA-covered benefits to participants and their beneficiaries.

Certain welfare benefit plans that would otherwise fall under ERISA have been specifically exempted by DOL regulations. These exemptions include:

- A safe harbor exemption for certain payroll practices, such as the payment of wages, unfunded sick leave and paid medical leave or unfunded vacation and holiday pay; and
- A safe harbor exemption for voluntary plans.

In addition to these exemptions, certain benefit arrangements do not fall under ERISA's definition of a welfare benefit plan. These include, for example, pet insurance, adoption assistance plans, dependent care assistance programs, liability or casualty insurance, or financial planning programs.

Exemption for Voluntary Plans

The DOL's safe harbor exemption for certain voluntary insurance arrangements generally applies where the full premiums are paid by employees and the employer has minimal involvement. To qualify as a voluntary plan under the DOL's safe harbor, the arrangement must be a group (or group-type) insurance program that satisfies the following requirements:

1. No contributions are made by the employer (or employee organization);
2. Employee participation in the program is completely voluntary;
3. The employer (or employee organization) receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs; and
4. The sole functions of the employer, with respect to the program, are, without endorsing the program, to permit the insurer to publicize the program to employees, collect premiums through payroll deductions or dues checkoffs, and remit them to the insurer.

Numerous DOL advisory opinions and court cases have addressed the DOL's safe harbor exemption for voluntary plans over the years. Unfortunately, the courts' decisions have not always been consistent, which has created some uncertainty regarding the safe harbor's parameters. However, there are some overall limits that employers should consider when reviewing the safe harbor exemption, as outlined below.

- **No Employer** Contributions

The safe harbor exemption does not apply to an insurance arrangement where the employer contributes toward the cost of the coverage. A plan would clearly fall outside the safe harbor if coverage were 100% employer-paid and free for all employees. The safe harbor is also inapplicable if the employer's contribution is only partial or insignificant or only for some employees. An employer is treated as contributing to the coverage regardless of whether it directly pays premiums to the insurer from its own funds or makes tax-free reimbursements to employees for their premium payments. However, an employer does not make contributions when it merely forwards the premium payments to the insurer for employees.

1. Voluntary Employee Participation

Employees' participation in a benefit program must be completely voluntary for the benefit to fall under the safe harbor exemption. Unlike other elements of the safe harbor exemption, this requirement is fairly straightforward. Requiring employees to participate in a benefit program (for example, making participation a condition of employment) would violate this safe harbor requirement.

2. No Employer Compensation

To qualify for the safe harbor exemption, the employer cannot receive any payments from the insurer offering the coverage other than reasonable compensation for administrative services actually rendered in connection with payroll deductions or dues checkoffs. The DOL has not provided guidance on what would qualify as reasonable compensation for purposes of the safe harbor exemption.

3. Limited Employer Involvement

The employer's involvement with the program is frequently the key to determining whether it is exempt from ERISA under the voluntary plan safe harbor. This determination is often difficult to make because it depends on the facts and circumstances involved with each specific benefit offering. If an employer endorses the program, it will fall outside the safe harbor and may be subject to ERISA. It is not exactly clear what factors (or combination of factors) may lead the DOL or a court to conclude that an employer has endorsed a program, but the safe harbor clearly allows an employer to perform the following three basic functions:

1. Permitting the insurer to publicize the program to employees;
2. Collecting premiums through payroll deductions; and
3. Remitting the premiums collected to the insurer.

Employers that want to take advantage of the safe harbor exemption should be cautious about engaging in activities that go beyond these three basic functions, as it is difficult to predict what actions the DOL or a court may view as an endorsement. For example, employer endorsement may include these actions:

- Selecting the insurer;
- Negotiating plan terms or linking coverage to employee status (e.g., providing a premium discount to current employees);
- Using the employer's name or associating the plan with other employee benefits;
- Recommending the plan to employees;
- Saying that the plan is subject to ERISA;
- Doing more than making payroll deductions (for example, sending premium notices or assuming liability for premium payments due during grace periods);
- Allowing employees to pay premiums on a pre-tax basis through the employer's Section 125 plan; and
- Assisting employees with claims or disputes.