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June 2015 Employee Benefits Update

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Select Compliance Deadlines and Reminders

1. Annual Benefit Statement for Calendar-Year Defined Contribution Plans with Plan-Directed Investments. Administrators of defined contribution plans that do not allow participant investment direction must provide an annual benefit statement to participants and beneficiaries by the date on which the Form 5500 is filed for the plan (but no later than the due date, including extensions, for filing the Form 5500) for the plan year to which the benefit statement relates. For a calendar-year plan, the benefit statement is due by the earlier of (a) the actual filing date of the 2014 Form 5500 or (b) July 31, 2015 (the plan's regular Form 5500 filing deadline), unless a Form 5500 deadline extension applies.

2. 2014 Form 5500 for Calendar-Year Plans. Plan administrators generally have seven months after the end of a plan year to file a Form 5500. For plan years ending December 31, 2014, the deadline for filing the Form 5500 is July 31, 2015. Plan sponsors that extended their corporate federal income tax return deadline can receive an automatic extension until September 15, 2015, if certain criteria are satisfied. Otherwise, plan administrators can apply for a deadline extension until October 15, 2015 by filing Form 5558 by July 31, 2015.

3. 2014 Form 8955-SSA and Individual Statement Deadline for Retirement Plans. Like the Form 5500, Form 8955-SSA *(Annual Registration Statement Identifying Separated Participants With Deferred Vested Benefits)* is due seven months after the end of a plan year (July 31, 2015 for calendar-year plans). A plan administrator can receive the same extension for the Form 8955-SSA as the Form 5500 by filing Form 5558 by July 31, 2015. Plan administrators must also provide the individual statements to those separated participants identified on the Form 8955-SSA prior to the deadline for filing the Form 8955-SSA.

Retirement Plan Developments

IRS Issues 2016 Limits for Health Savings Accounts ("HSAs")

The Internal Revenue Service ("IRS") issued Rev. Proc. 2015-30, which provides inflation adjusted amounts for HSAs as follows:

- Annual limitation on deductions:
  - Self-only coverage is $3,350
  - Family coverage is $6,750
- "High Deductible Health Plan" is a health plan that meets the following requirements:
  - annual deductible is not less than $1,300 for self-only coverage ($2,600 for family coverage); and
  - annual out-of-pocket expenses (deductibles, co-payments and other amounts, but not premiums) do not exceed $6,550 for self-only coverage ($13,100 for family coverage).

IRS Cautions Administrators to Document Hardship Distributions and Plan Loans

In a recent Employee Plans News, the IRS advised plan administrators, including those who employ third parties to provide such services, to retain records of each hardship distribution and plan loan made to a participant. The IRS noted that failing to have these records available is a qualification failure that must be corrected under Employee Plans Compliance Resolution System ("EPCRS").

For hardship distributions, the IRS recommends that plan administrators retain the following records:

- documentation of the hardship request, review and approval;
- financial information and documentation substantiating the employee's immediate and heavy financial need;
- documentation supporting that the hardship distribution was properly made under the plan provisions and the Internal Revenue Code; and
- proof of the actual distribution made and related Form 1099-R.

For participant loans, the IRS recommends that plan administrators retain the following records:

- evidence of the loan application, review and approval process;
- an executed plan loan note;
- if applicable, documentation verifying that the loan proceeds were used to purchase or construct a primary residence;
- evidence of loan repayments;
- evidence of collection activities associated with loans in default and the related Form 1099-R, if applicable; and
- if a participant requests a loan with a repayment period over five years to purchase or construct a primary residence, documentation of the home purchase prior to approval of the loan.

PBGC Clarifies that Proposed Rule Related to Mandatory Electronic Filing Applies Only to Notices to PBGC

After issuing a recent proposed rule relating to electronic filing of certain multiemployer notices and applications, the PBGC received questions regarding whether the proposed rule affected notices to participants. The PBGC recently clarified that the proposed rule affects only notices to the PBGC (i.e., notices of termination, notices of insolvency and applications for financial assistance). The PBGC also noted that the proposed rule does not involve the Multiemployer Pension Reform Act of 2014.

Health and Welfare Plan Developments

Departments Issue New FAQs Regarding Preventive Services

In a recent set of FAQs, the IRS, the Department of Labor ("DOL") and the Department of Health and Human Services ("HHS") (collectively, the "Departments") provided guidance on several issues related to contraceptive services and other preventive services required by the Affordable Care Act ("ACA").

- Contraceptive Services. Effective the first plan year beginning on and after August 1, 2015, plans must cover at least one form of contraception in each of the 18 FDA-approved methods of birth control (e.g., sterilization surgery, IUD, different forms of oral contraceptives, shot/injection) without cost-sharing.

Plans may continue to use reasonable medical management techniques to encourage use of specific forms within each method. Plans that use reasonable medical management must have an "easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the individual or provider." However, if the individual's attending provider recommends a particular service or FDA-approved item based on a determination of medical necessity, the plan must cover that service or item without cost sharing.

- BRCA Testing. The plan must cover, without cost sharing, recommended genetic counseling and BRCA testing for a woman previously diagnosed with non-BRCA related cancer.
- Transgender Individuals. Sex-specific preventive care services must be covered for transgender individuals if the individual's attending provider determines the service is medically appropriate and the individual otherwise satisfies the criteria for the service. The FAQs provide the following example: A transgender man with an intact cervix or residual breast tissue would be eligible for a pap smear or mammogram.
- Colonoscopy. Anesthesia services performed in connection with a preventive colonoscopy must be covered at 100% in-network if the attending provider determines anesthesia would be medically appropriate.

Departments Issue FAQs on Limitations of Cost Sharing and Provider Nondiscrimination

The Departments jointly issued FAQs affirming that the self-only annual limit applies to each covered individual, regardless of whether the coverage is self-only or family coverage. This guidance applies to all non-grandfathered group health plans for years beginning in 2016 or later.

Additionally, the FAQs respond to questions regarding the prohibition on discriminating against health care providers acting within the scope of their licenses or certifications. In a prior FAQ, the Departments stated that if an item or service is a covered benefit under a plan, a plan must not discriminate based on a health care provider's license or certification, assuming the provider is acting within the scope of the provider's license or certification under applicable state law. The recent FAQs retract the earlier guidance and state that the Departments will take no enforcement action against a plan or insurer under the

nondiscrimination rule, provided the plan or insurer is using a reasonable good faith interpretation of the statutory provision.