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Discovery Benefits

**Flexible Benefits
Employer Guide**

FSA · HSA · HRA · COBRA · Transportation

Save thousands on FICA contributions every year!

A Flexible Benefits Plan through Discovery Benefits will:

- Increase employee retention and satisfaction
- Save matching FICA contributions dollar for dollar
- Cut medical and dependent care costs while boosting take-home pay for your employees

Good for your employees. Good for you.

Employees can deduct pre-tax dollars to pay for qualified insurance premiums, medical and dependent care expenses, and you can save matching FICA contributions for every dollar they deduct.

Discovery Benefits makes it simple

We handle everything, including all interaction and account questions from your employees. We offer 24/7 account access with fast online enrollment, and we send reimbursements directly to your employees' homes or bank accounts.

We provide:

- Simplified enrollment and communication materials
- Plan document and SPD preparation and updates
- Electronic reporting
- Easy payroll import
- Simplified education and support
- Free direct deposit
- Benefits Debit Card

A Flexible Benefits Plan from Discovery Benefits is a simple way to save money while enhancing your health plan. Start today!



Getting started is easy. Find everything you need to enroll at:

www.DiscoveryBenefits.com

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A Flexible Benefits Plan simply saves you money.

There are two components in a Flexible Benefits Plan:

Premium Conversion Account

This pre-tax money can be used to automatically pay for employees' qualified insurance premiums, including:

- Group health, dental, vision and prescription drug insurance
- Disability insurance
- Life insurance (up to \$50,000 face value)
- Voluntary health care benefits

Flexible Spending Account

This money can be used by employees to pay for medical expenses not covered by insurance, and for dependent care for children and/or a disabled dependent. A Flexible Spending Account is broken into two types:

- **Medical Spending Account** – Employees can set aside pre-tax dollars for qualified medical expenses including medical, dental and vision expenses, prescription drugs, medical supplies and some over-the-counter medications. You set the maximum amount an employee can set aside each plan year.
- **Dependent Care Spending Account** – Employees can set aside pre-tax dollars to pay for day care for children under 13, a disabled spouse or dependent.

The following IRS maximums apply to dependent care accounts

- Married couples filing jointly: Annual account deposit maximum - \$5,000
- Married couples filing separately: Annual account deposit maximum - \$5,000 (a maximum of \$2,500 each)
- Single head of household: Annual account deposit maximum - \$5,000

Eligible companies

- C Corporation
- Subchapter S Corporation
- Sole Proprietorship
- Limited Liability Corporation (LLC)
- Partnership

You define “Eligible Employee” within guidelines. You can exclude:

- Part-time employees working fewer than a specified number of hours not to exceed 35 hours
- Commissioned employees
- Union employees
- Nonresident alien employees

Ineligible individuals:

- Sole proprietor
- Partner who owns 2% or more of the business
- Sub-S Corporation owner with 2% or more ownership and their employed spouse or dependent
- LLC owner

Plan year

It's usually a 12-month period that begins with the effective date of the plan. A short plan year is allowed for the first plan year or when you're changing the plan year to match the benefit or fiscal year or other qualified business reasons. You can't have two short plan years in a row.

The Benefits Debit Card makes it simple

Upon enrollment, your employees can receive a Benefits Debit Card that draws money directly from their spending accounts to pay for qualifying expenses.

- There's no out-of-pocket expense at time of service
- There's no waiting for reimbursement
- Payments are made directly from their spending account to the provider
- Additional debit cards for spouse and/or dependents available at no additional charge

Companies that offer the Benefits Debit Card:

- Experience up to a 40% increase in the number of participants joining the Flexible Benefits Plan
- See up to a 40% increase in flex dollars elected each year per participant
- Benefit from increased employee knowledge and education on the benefits of flex

When not using the card, employees can submit reimbursement requests via fax, online, email or mail. We'll mail them a check or deposit the amount in their bank account with FREE direct deposit.

Employee account activity is tracked individually on our system with reports sent to you, whenever you choose. Or, you can access reports any time through the Employer Web Portal. You provide funds from your general assets to Discovery Benefits as needed to pay claims. We'll send an email notice of the debit amount 24 hours in advance of any debit. If you wish, you can send contributions to us each pay period as another banking option.

Flexible Benefits Plan payroll adjustment

	Premium Conversion	Medical Spending Account	Dependent Care Spending Account
Federal Income Tax	Exempt	Exempt	Exempt
State Income Tax	Exempt in all states except New Jersey and Puerto Rico	Exempt in all states except New Jersey and Puerto Rico	Exempt in all states except New Jersey and Puerto Rico
FICA (Social Sec. & Medicare)	Exempt	Exempt	Exempt
FUTA	Exempt	Exempt	Exempt
SUTA	Exempt in AZ, CA, CO, GA, ID, IN, NE, NC, OH, SC, UT, VA, WI only. Taxable in all other states.	Exempt in AZ, CA, CO, GA, ID, IN, NE, NC, OH, SC, UT, VA, WI only. Taxable in all other states.	Exempt in AZ, CA, CO, GA, ID, IN, NE, NC, OH, SC, UT, VA, WI only. Taxable in all other states.

W-2

Employee premiums for qualified insured benefits paid pre-tax through a Flexible Benefits Plan and Medical Spending Account elections are not reported on the W-2. The dependent care election is reported in Box 10 of the employee's W-2. Employees report this using IRS Form 2441.

IRS "At Risk Rule"

When you offer Medical Spending Accounts to your employees, there is a chance you could lose some money from employees who terminate or experience a status change event during the plan year. It's because with the Medical Spending Account, you must make available the full amount elected by the employee at all times during the plan year. For example, if an employee elects \$600/year for the Medical spending Account, pays the first \$50 and incurs a \$400 expense, you must reimburse them for the entire \$400, even though their contributions only total \$50. And if the employee terminates before you are able to deduct the remaining contributions from their paycheck, you're left with a negative balance.

The "At Risk Rule" does not apply to the Dependent Care Spending Account.

Ways to minimize the IRS "At Risk Rule":

- Only allowing increases to Medical Spending Account elections when there's a status change
- Limiting how much employees can contribute to a Medical Spending Account
- Limiting the type of medical expenses eligible for reimbursement
- Requiring a longer eligibility period
- Limiting the types of status changes allowed

Forfeited funds are returned to you

Because the IRS has a "Use It or Lose It" rule, contributions left in the spending accounts by the close of the plan year run out period, are returned to you. You can use the money to offset administrative expenses or you can return it to the participants. If you return the funds, you must allocate them fairly and on a uniform basis. You can't allocate them based on individual claim experience.

Grace period extension

The IRS now allows you to extend the period in which employees can incur claims up to 2 1/2 months beyond the end of the plan year. The extension is voluntary and is not required. If you're amending your plan to add the extension, you may also want to consider extending the run-out period an additional 30 days to allow employees time to submit claims requiring insurance processing. It's recommended that you not include the 2 1/2 month grace period if offering a Health Spending Account (HSA), because it affects employee eligibility for an HSA, even if they are not participating in the FSA in the new plan year.

Assumptive enrollment

For second and subsequent plan year renewals, you can use assumptive enrollment for insured benefits provided through Premium Conversion. Automatic enrollment means that an employee's insured benefit election remains the same as the previous plan year unless the employee completes an enrollment form indicating a change in election. You need to communicate the rules for changes in elections during the plan year and provide enough time for them to change elections before the start of a new plan year.

The IRS has the following rules:

- Adequate notice of the process and the right to decline coverage
- Information on the procedures for declining coverage
- Information about when the election must be made and how long it will be effective

Flexible Spending Account elections must be made prior to the start of each plan year. If a new election is not made, the individual will not be enrolled in the Flexible Spending Accounts for the new plan year.

Automatic claim rollover

Discovery Benefits accepts automatic claim rollover files from health carriers and health claim administrators willing to provide a rollover file. With this option, the carrier sends a file of participant medical expenses directly to us. We reimburse the participant based on the information in the file, eliminating the need for them to submit a manual claim.

Eligible medical expenses not covered by insurance and dependent care expenses still need to be submitted to us for reimbursement from the spending account. Employees issued a Benefits Debit Card can't participate in the automatic rollover as it will result in duplicate reimbursement.



Rules for changing elections

There's a two-step analysis to determine if an employee can change elections during the year:

1. There's been a status change event
2. The requested election change is consistent with the event

An election change satisfies the requirements of the “consistency rule” for 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 your plan. A change in coverage eligibility is not required for a status change for group term life insurance, AD&D or long-term disability insurance.

Status change events

An employee can't change their election during the plan year unless they experience one of the following status change events. Status changes apply to Premium Conversion and Flexible Spending Accounts:

- Marriage
- Death of spouse
- Divorce
- Legal separation
- Annulment
- Residence change of employee, spouse or dependent

The employee has 30 days to submit the status change form to you. The change is effective on the later of the election date or the date of the status change event. Retroactive changes aren't allowed.

Change in employment status (for the employee or dependent)

IRS rules say that if there's a change in employment status resulting in a change in eligibility for the plan for the employee, spouse or dependent of the employee, it's considered a change in employment status. For example, if a plan is for salaried employees only and an employee switches from salaried to hourly, the employee is no longer eligible for the plan. Other employment status changes are:

- Job termination
- Retirement
- Strike/lockout
- Commencement or return from unpaid leave
- Change in worksite location
- Loss of eligibility as the result of qualifying event

Dependent eligibility requirements

Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage or account of attainment of age, student status, or any similar circumstance.

Change in number of dependents

Events that change an employee's number of dependents including: birth, death, adoption, and placement for adoption. A dependent is formally defined in the final regulations to be a tax dependent under Code Section 152. This rule would not allow election changes for non-tax dependents such as parents, domestic partners and children of domestic partners.

Dependent and adoption assistance benefits

The "consistency rule" is satisfied for dependent care and adoption assistance benefits if:

1. The election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan; or
2. The election change is on account of and corresponds with a change in status that affects dependent care or adoption assistance expenses.

A dependent child turning 13 would affect eligibility for dependent care expenses under Number 1. A dependent care assistance election may be cancelled when a dependent child turns 13 in the middle of the plan year and is no longer a qualifying individual. An employee changing day care providers would constitute a coverage change under Number 2.

Dependent care provider changes

For changes with dependent care, you can look to the coverage change rules. When an employee switches day care providers, it's a coverage change and they can change their election. If an employee wants to go from using a day care center to using a relative to take care of the child, that's a coverage change and the employee can make an election change to reflect a change in the costs.

There is a rule that doesn't allow cost increases for dependent care when the day care provider is a relative.

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Cost/coverage changes

The cost or coverage provisions apply to qualified benefits, including dependent care, adoption assistance and self-funded medical coverage. The cost or coverage change rules do not apply to Medical Spending Accounts.

Automatic increases or decreases

If the cost of a qualified benefit plan increases (or decreases) during a period of coverage and, under the terms of the plan, employees are required to make a corresponding change in their payments, the Flexible Benefits Plan may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in affected employees' elective contributions for the plan.

Significant cost increases

If the cost of a benefit package increases significantly during a period of coverage, employees can make a corresponding prospective increase in their payments or revoke their elections on a prospective basis to find coverage under another benefit package with similar coverage. Employees can drop coverage if no other option provides similar coverage. This also applies to dependent care, if the provider, who is not a relative of the employee, imposes the cost change.

Significant coverage changes

If the coverage under a plan is significantly cut or ceases during the period of coverage, the Flexible Benefits Plan may permit affected employees to revoke their elections. In that case, employees can make a new election on a prospective basis for coverage under another benefit package with similar coverage.

Addition (or elimination) of benefit package option providing similar coverage

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

Change in coverage of a spouse or dependent under other employer's plan

A Flexible Benefits Plan may permit an employee to make a prospective election change that is on account of and corresponds with a change made under the plan of the spouse's, former spouse or dependent's employer if:

- A qualified benefit plan of the spouse's, former spouse's, or dependent's employer permits participants to make an election change that would be permitted under a qualified status change.
- The Flexible Benefits Plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan or qualified benefits plan of the spouse's, former spouse's or dependent's employer.

Other allowed coverage changes

If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for an employee's child or foster child who is a dependent, a Flexible Benefits Plan will be allowed to:

- Make changes to the employee's election to provide coverage for the child if the order requires coverage under the employee's plan
- Permit the employee to make an election change to cancel coverage for the child if the order requires the spouse, former spouse, or other individual to provide coverage for the child.

Entitlement to Medicare or Medicaid

If an employee, spouse, or dependent who is enrolled in an accident or health plan of the employer becomes enrolled in Part A or Part B of Medicare or Medicaid, a Flexible Benefits Plan may permit the employee to make a prospective election change to cancel or reduce coverage of that employee, spouse, or dependent under the accident or health plan. In addition, if an employee, spouse, or dependent who has been covered by Medicare or Medicaid and loses eligibility for such coverage, the Flexible Benefits Plan may permit the employee to make a prospective election change to commence or increase coverage of that employee, spouse, or dependent under the accident or health plan.

Special requirements relating to the Family and Medical Leave Act

An employee taking leave under FMLA can revoke an existing election of group health coverage and make another election for the remaining period of coverage as provided under FMLA.

COBRA

If the employee, spouse or dependent becomes eligible for continuation coverage under the group health plan you've provided by COBRA or any similar state law, a Flexible Benefits Plan allows that employee to elect to increase payments under your Flexible Benefits Plan to pay for the continuation coverage.

HIPAA special enrollment rights

HIPAA stands for Health Insurance Portability and Accountability Act. An employee may change a Flexible Benefits Plan election for group health plan coverage to the extent the election change "corresponds" with the special enrollment rights under HIPAA.

If an employee is eligible to enroll in your group health plan or add coverage for a family member under HIPAA, they can make a conforming election under the Flexible Benefits Plan. This allows required contributions for such health coverage to be paid on a pre-tax basis.

Examples in the final regulations clarify that if an employee, spouse, or dependent is entitled to enroll in a group health plan under the HIPAA special enrollment rules, a Flexible Benefits Plan may permit the employee to elect to enroll pre-existing dependents in the underlying group health plan. The final regulations carve out a narrow exception to the general rule prohibiting retroactive election changes under a Flexible Benefits Plan. Under HIPAA, if a newborn or adopted child is enrolled within the HIPAA special enrollment period, which may not be less than 30 days, the child's coverage must be retroactive to the date of birth, adoption, or placement for adoption. The regulations provide that a Flexible Benefits Plan may permit the employee to change his or her salary reduction election (for future pay periods) to pay for the extra cost of the child's coverage retroactive to the date of birth or adoption.



Separation from service

A Flexible Benefits Plan may permit an employee who separates from service of the employer during a period of coverage to revoke the existing Dependent Care Spending Account election and terminate the receipt of benefits for the remaining portion of the coverage period. If an employee returns to employment within 30 days of termination and wishes to elect the same benefits held prior to termination, the employee would only be allowed to step back into the elections held prior to leaving employment.

Accident or Health Plans, Group-Term Life Plans

Separation from service is considered a status change for accident or health and group-term life plans. Coverage would cease in accordance with the employer's Flexible Benefits Plan (although the benefits may still be subject to COBRA continuation coverage). If an employee returns to employment with your company within 30 days of termination and wishes to elect the same benefits held prior to termination, the employee would only be allowed to step back into the elections held prior to leaving employment.

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Plan documents/filing requirements

Section 125 regulations require a written document that contains specific information about your company's plan. We collect this information prior to the start of each plan year with our design guide. Included with your plan document is a Summary Plan Description. The Department of Labor requires that a copy of it be provided to each participant in the program within 120 days of the beginning of each plan year. It's a useful resource that covers frequently asked questions, how to submit reimbursement requests and what claims are eligible.

The Balanced Budget Act contained a provision (Section 1503) that eliminates the ERISA requirement that Summary Plan Descriptions and Summaries of Material Modifications be filed with the Department of Labor. The provision preserves the requirement that documents must be provided to the Department of Labor upon request by the DOL.

IRS Form 5500

The IRS issued Notice 2002-24 suspending the requirement for Flexible Benefit Plans to file Form 5500 or Schedule F to satisfy the IRC Sec. 6039D filing requirement. This IRS notice did not suspend the Form 5500 filing requirement for ERISA welfare benefit plans that are required to file Form 5500. Medical Spending Accounts are considered ERISA welfare benefit plans.

The following is a summary of the filing requirements for Discovery Benefits administered Flexible Benefit Plans where your general assets are used to reimburse Medical Spending Account claims. It's a summary only. Neither Discovery Benefits nor its employees or agents provide legal or tax advice or are authorized to do so. Consult with your tax/legal counsel to determine your filing requirements.

Premium conversion only

Under 100 participants at the beginning of the plan year:

- No Form 5500 is required.

Over 100 participants at the beginning of the plan year:

- No separate Form 5500 is required.
- Form 5500 is required for the entire health plan itself. If it's unfunded, fully insured or a combination of unfunded/insured (e.g. self-funded with stop loss coverage), the health plan is exempt from the accountant's report (plan audit) requirement and from filing Schedule H.
- Summary annual report must be provided to participants of the entire health plan.

Medical Spending Accounts

Under 100 participants at the beginning of the plan year:

- No separate Form 5500.

Over 100 participants at the beginning of the plan year:

- Form 5500 is required for Medical Spending Accounts.
- Form 5500 is required for the entire health plan itself. If it's unfunded, fully insured or a combination of unfunded/insured (e.g. self-funded with stop loss coverage), the health plan is exempt from the accountant's report (plan audit) requirement and from filing Schedule H.
- Summary annual report must be provided to participants of the entire health plan.

Welfare plans not subject to ERISA and exempt from filing Form 5500:

- Governmental plans
- Church plans
- DOL regulations exempt payroll practices; certain voluntary plans; unfunded scholarship programs (e.g. educational assistance programs)

Discrimination testing requirements

Flex Benefit Plans are subject to several discrimination tests. To test, you need to determine which employees are considered Highly-Compensated and/or Key according to IRS definitions.

A Highly-Compensated Employee:

- Is considered an officer
- Is considered a shareholder owning more than 5% of the voting power or value of all classes of stock of the employer
- Is highly-compensated (The IRC does not define this. It is believed that the definition of Highly-Compensated Employees under the IRC Section 414(q) can be used in this instance.)
- Is a spouse or dependent (within the meaning of IRC Section 152) of the above employees or owners
- Is more than 5% owner during the prior or current plan year
- Is a spouse or relative (within the meaning of IRC Section 318) of any officer
- Earned more than \$100,000 (indexed) in the prior year
- An employer may elect to treat as highly-compensated, under the \$60,000 compensation test only those employees who are also in the top-paid 20% group. The \$100,000 amount is subject to cost of living adjustments. Some employees can be excluded when determining the top-paid group. These employees include those who:
 - Have not completed six months of service
 - Normally work less than 17 hours per week
 - Normally work under six months per year
 - Are union members
 - Are nonresident aliens
 - Are under age 21

A Key Employee is:

An employee who, at anytime in the proceeding plan year, is:

- An officer with annual compensation in excess of \$145,000 (indexed)
- More than a 5% owner of the employer
- More than a 1% owner of the employer and has compensation in excess of \$150,000

This new definition does not contain the four-year block look back rule. No more than 50 employees shall be treated as officers. If there are fewer than 50 employees who are treated as officers, no more than the greater of 1) three employees or 2) 10% of all employees will be treated as officers.

Generally the term “officer” means an administrative executive. According to regulations under 414(q), an officer includes the president, vice-presidents, general manager, treasurer, secretary and controller of a corporation and any other person who performs duties corresponding to those normally performed by persons occupying those positions.

Compensation includes taxable compensation and salary reductions under the Flexible Benefits Plan, 401(k) plans and tax-sheltered annuities. Stock owned by an employee’s spouse, children, grandchildren or parents is treated as owned by the employee.

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Section 125 objective discrimination testing

We run annual discrimination tests for the following three sections based on information from you:

Section 125 25% Concentration Test

No more than 25% of the aggregate of the statutory nontaxable benefits provided to all employees under all the plans may be provided to Key Employees.

Section 129 25% Concentration Test (Dependent Care Spending Account)

No more than 25% of the amounts paid or incurred by the employer for dependent care assistance during the year may be provided for the class of individuals who are shareholders or owners (or their spouses or dependents).

Section 129 55% Average Benefits Test (Dependent Care Spending Account)

The average benefits provided to employees who are not highly-compensated under all plans of the employer must be at least 55% of the average benefits provided to Highly-Compensated Employees under all plans of the employer.

Consequences of discrimination

If the plan does not pass the 25% Concentration Test of IRC Section 125(b)(2), only the Key Employees are taxed on available benefits. If the Dependent Care Spending Account is discriminatory, benefits provided to principal shareholders or owners or to Highly-Compensated Employees are taxable. Such benefits are not considered to be qualified benefits and are not included in the overall tests (eligibility, contributions, and benefits) under IRC Section 125. Ultimately, the responsibility for discrimination testing is yours. A description of other tests required for Section 125 plans is attached.



Additional Section 125 discrimination tests

The following subjective IRS discrimination tests also apply to Section 125 plans. These tests remain the responsibility of the employer and are briefly described below for your information.

Safe Harbor Test

The Safe Harbor Tests are applied only to health insurance benefits included in a Flexible Benefits Plan. Failing the Safe Harbor Test does not mean that a plan is discriminatory. It means the other facts and circumstances of the plan should be reviewed to determine any possible discrimination. The Internal Revenue Service has not explained this test in the regulations; furthermore, certain authoritative representatives with the IRS have said that this test has no meaning.

A plan will not be discriminatory with respect to insurance if contributions for health insurance under the plan on behalf of each participant include an amount which:

- Equals 100% of the cost of the health benefit coverage under the plan of the majority of similarly situated Highly-Compensated Employees; or
- Equals or exceeds 75% of the cost of the health benefit coverage of the participant (similarly situated) having the highest cost health benefit coverage under the plan; and
- Contributions or benefits under the plan in excess of those described above bear a uniform relationship to compensation



Eligibility test

A plan will not be treated as discriminatory to eligibility if the plan benefits a group of employees who qualify under a classification established by the employer and found by the IRS not to be in favor of Highly-Compensated Employees [see IRC Section 410(b)(2)(A)(i)]; and meets the requirements of 1 and 2 below:

1. No employee is required to complete more than three years of service with the employer maintaining the plan as a condition of participation in the plan and this employment requirement is the same for each employee.
2. An employee who has satisfied the employment requirement of number 1 above and who is otherwise entitled to participate in the plan commences participation no later than the first day of the plan year beginning after the date the employment requirement was satisfied - unless the employee was separated from service before the first day of that plan year.

Contributions and benefits

A plan will not be discriminatory as to contributions and benefits and nontaxable benefits do not discriminate in favor of Highly-Compensated Employees.

Consequences of discrimination

If a Flexible Benefits Plan is determined to be discriminatory in the overall test (eligibility, contributions, and benefits), the plan does not cease to be a Flexible Benefits Plan; however, participants who are highly-compensated will be taxed on the maximum taxable benefit that could have been selected for the plan year. Benefits paid top participants who are not highly-compensated may be excluded entirely from gross income even if the plan is discriminatory.

Facts and circumstances

The first subjective test states that contributions or benefits provided under the plan shall not discriminate in favor of employees who are highly-compensated or their dependents. The second subjective test states the plan must benefit employees who qualify under a classification set up by the employer and found by the IRS not to be discriminatory in favor of employees who are highly-compensated or their dependents [IRC Section 410(b)(2)(A)(i)].

Consequences of discrimination

If the Dependent Care Spending Account is determined to be discriminatory, benefits provided to principal shareholders or owners or to Highly-Compensated Employees are taxable. Such benefits are not considered to be qualified benefits and are not included in the overall tests (eligibility, contributions, and benefits) under IRC Section 125.

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Section 105

Medical Spending Account Plans are first tested for discrimination under IRC Section 105. If the plan is determined to be nondiscriminatory, these benefits are considered nontaxable benefits and are aggregated with other Flexible Benefits Plan benefits and tested under Section 125.

Facts and circumstances

The first subjective test states that a plan cannot discriminate in favor of Highly-Compensated Employees in actual operation based on facts and circumstances in each case.

The second subjective test states that this test is met if a plan benefits such employees as qualify under a classification of employees set up by the employer which is found by the IRS not to be discriminatory in favor of Highly-Compensated Employees. This determination will be based upon the facts and circumstances of each case, applying the same standards as are applied under Section 410(b)(2)(A) relating to qualified retirement plans.

In addition to the facts and circumstances test, there is a three-part objective test which must be met.

1. The first part is a percentage test and is satisfied if the plan benefits:
 - 70% or more of all employees; or
 - 80% or more of all the employees who are eligible to benefit under the plan if 70% or more of all employees are eligible to benefit under the plan
2. The second part allows for the exclusion of certain employees:
 - Employees with less than three years of service
 - Employees who have not attained age 25 prior to the beginning of the plan year
 - Part-time employees who usually work less than 35 hours
 - Employees who are covered by a collective bargaining agreement, if accident and health benefits were the subject of good faith bargaining
 - Employees who are nonresident aliens who receive no U.S. source income from the employer
3. The third test states that benefits subject to reimbursement under a plan must not discriminate in favor of Highly-Compensated Employees. All of the plan benefits provided for participants who are Highly-Compensated Employees must be provided for all other participants. This test is applied to the benefits available rather than the expenses reimbursed.

Consequences of discrimination

A medical reimbursement plan may be considered discriminatory based on ineligibility and/or availability of benefits subject to reimbursement. If a plan is discriminatory as to:

$$\text{Excess Reimbursement} = \frac{\text{Amount reimbursed to Highly-Compensated Employees}}{\text{Total amount reimbursed to Highly-Compensated Employees}} \times \frac{\text{Total amount reimbursed to Highly-Compensated Employees}}{\text{Total amount reimbursed to all plan participants}}$$

Section 79 Group Life Insurance

Under Section 79, a group term life plan provides for an exclusion from taxable income for the cost of coverage up to \$50,000. A discriminatory plan is one that discriminates in favor of Key Employees as to eligibility to participate or as to the type or amount of benefits available under the plan.

Eligibility test

A plan will not discriminate as to an employee's eligibility to participate if one of the following tests is met:

- The plan benefits 70% or more of all employees
- At least 85% of all employees who are participants under the plan are not Key Employees
- The plan benefits such employees as qualify under a classification set up by the employer and found by the IRS not to be discriminatory in favor of Key Employees
- If the benefits are offered as part of a Section 125 plan, the eligibility requirements of Section 125 are satisfied

With regard to this test, the following classes of employees may be excluded:

- Employees with less than three years of service
- Part-time or seasonal employees
- Nonresident aliens with no U.S. source earned income from the employer
- Employees who are covered by a collective bargaining agreement where the plan benefits were the subject of good faith bargaining

Benefits test

Benefits are discriminatory unless the plan provides:

- A fixed amount of insurance that is the same for all covered employees
- Coverage based on a uniform percentage of total compensation or of basic compensation
- Benefits which are nondiscriminatory based on all the facts and circumstances

Consequences of discrimination

The exclusion of the premium from income does not apply to Key Employees.



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We're transforming the complexity of employee benefits administration with extraordinary customer service, unique product solutions and smarter technologies.

Simply put, we work hard to make it easy to do business with us.