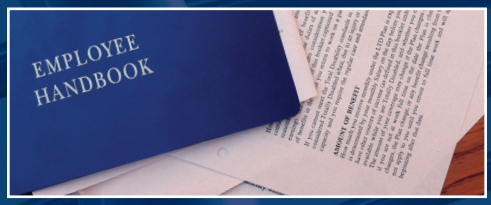
FOSTER SWIFT
FOSTER SWIFT COLLINS & SMITH PC | ATTORNEYS



Employment Labor & Benefits Quarterly

Summer 2012

FINAL RULE ISSUED REGARDING SUMMARY OF BENEFITS AND COVERAGE REQUIREMENT

- Johanna M. Novak

The Internal Revenue Service, Department of Labor and Department of Health and Human Services (collectively, the "Department") published final regulations describing the summary of benefits and coverage ("SBC") requirement of the Patient Protection and Affordable Care Act ("PPACA").

The requirement to provide an SBC applies for disclosures to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For participants or beneficiaries who enroll in group health coverage other than through an open enrollment period, the requirement applies on the first day of the first plan year that begins on or after September 23, 2012. The SBC requirement applies to both fully-insured and self-insured plans, regardless of grandfathered plan status.

A written SBC must be provided without charge to the participant and beneficiary with respect to each benefit package offered by the plan for which the participant or beneficiary is eligible. The SBC must be provided as part of any written application materials that are distributed by the plan for enrollment. Under certain circumstances, the plan must also provide the SBC:

1. after certain changes are made to the SBC,
2. to special enrollees,
3. upon request,
4. and upon renewal of coverage.

These distribution requirements also apply to health insurance issuers. A group health plan required to provide an SBC to participants and beneficiaries satisfies its obligation if another party provides the SBC to the participants or beneficiaries. For example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual.

If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC is generally satisfied. However, if the beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at his or her last known address.

The SBC must contain certain mandated language, including but not limited to, a description of the coverage, any exceptions or limitations of coverage, uniform definitions of standard insurance terms, and coverage examples. An SBC template is available at www.dol.gov/ebsa/healthreform under the heading "Summary of Benefits and Coverage and Uniform Glossary". Instructions for completing the template are also available at this link.

The SBC may not exceed 4 double-sided pages in length and may not include print smaller than 12-point font. The SBC may be provided in electronic form if certain distribution requirements are met.

If a plan or issuer makes any material modification to any of the terms of the plan, or coverage that would affect the SBC's content that is not reflected in the most recently provided SBC and that occurs other than in connection with a renewal or reissuance of coverage, then the plan or issuer must provide notice of the modification to enrollees not later than 60 days before the date on which the modification will become effective.

In addition to the requirement to provide an SBC, a group health plan or health insurance issuer must also make available to participants and beneficiaries a uniform glossary of certain health-coverage-related terms and medical terms. A template glossary can be found at the website noted above. The glossary must be made available upon request, in either paper or electronic form (as requested), within 7 business days after receipt of the request.

A group health plan or health insurance issuer that willfully fails to provide information required by these regulations is subject to a fine of not more than $1,000 for each such failure.

Johanna M. Novak
Attorney
P: 906.226.5501
E: jnovak@fosterswift.com

IRS ANNOUNCES 2013 HSA CONTRIBUTION LIMITS, OUT-OF-POCKET MAXIMUMS AND HDHP MINIMUM DEDUCTIBLES

- Lauren B. Dunn

The Internal Revenue Service recently released the 2013 health savings account ("HSA") contribution limits, out-of-pocket maximums and high deductible health plan ("HDHP") deductibles. Each of the cost-of-living adjusted amounts is set forth below.

HSA Contribution Limits. The 2013 annual HSA contribution limit for an individual with self-only HDHP coverage is $3,250, and the limit for an individual with family HDHP coverage is $6,450. The 2013 annual HSA contribution limits have increased by $150 and $200, respectively, from 2012.

HDHP Minimum Annual Deductibles. The 2013 HDHP minimum annual deductible for an individual with self-only coverage is $1,250, and the minimum annual deductible for an individual with family HDHP coverage is $2,500. The HDHP minimum annual deductible amounts have increased by $50 and $100, respectively, from 2012.

HDHP Out-of-Pocket Maximums. The 2013 HDHP out-of-pocket maximum for an individual with self-only coverage is $6,250, and the out-of-pocket maximum for an individual with family coverage is $12,500. The HDHP out-of-pocket maximum amounts have increased by $200 and $400, respectively, from 2012. (Out-of-pocket expenses include co-insurance, co-payments and deductibles, but not HDHP insurance premiums.)

Although each of the foregoing increased limits will take effect January 1, 2013, the new limits for each category (i.e., self-only or family) were not identically increased. Such variations may have practical consequences, such as causing an individual to incur more out-of-pocket expenses because the HSA contribution limit is not increasing at the same rate as the HDHP minimum annual deductibles and out-of-pocket maximums. In addition, the greater difference between the 2013 HDHP minimum annual deductibles and out-of-pocket maximums give plan sponsors greater flexibility in determining potential deductibles. (HDHP deductibles can be set as high as the applicable out-of-pocket maximum.) However, beginning in 2014, the foregoing flexibility will not be available to non-grandfathered plans under the Patient Protection and Affordable Care Act when the limit on annual deductibles takes effect.

Please contact your Foster Swift employee benefits professional if you have any questions.

IRS ISSUES GUIDANCE ON $2,500 LIMIT FOR SALARY REDUCTION CONTRIBUTIONS TO A HEALTH FSA

- Lauren B. Dunn

The Internal Revenue Service ("IRS") recently issued guidance regarding the $2,500 limit on salary reduction contributions to a health flexible spending account ("Health FSA") under the Patient Protection and Affordable Care Act ("PPACA"). IRS Notice 2012-40 clarifies that the $2,500 limit applies (generally effective January 1, 2013) to employee salary reduction contributions and does not apply to employer nonelective contributions to a Health FSA. Other important aspects of IRS Notice 2012-40 are described below.

Plan Year Basis. The $2,500 limit on salary reduction contributions to a Health FSA is effective for taxable years beginning after December 31, 2012. The Notice clarifies that the term "taxable years" refers to the plan year of the cafeteria plan under which the Health FSA is offered. Therefore, the $2,500 limit applies to plan years that begin after December 31, 2012. A cafeteria plan with a calendar plan year will have to comply with the limit beginning on January 1, 2013.

Short Plan Year. If a cafeteria plan has a short plan year (less than 12 months) that begins after December 31, 2012, the $2,500 limit must be prorated based on the number of complete months in that short plan year.

Per Employee Basis. The $2,500 limit applies on a per employee basis. Therefore, an employee and his or her spouse can each make Health FSA salary reduction contributions up to the $2,500 limit (even if the employee and his or her spouse work for the same employer and participate in the same Health FSA).

Grace Period. Unused salary reduction contributions from one plan year that are carried over into a grace period do not count against the $2,500 limit for the next plan year.

Amendment. Cafeteria plans must adopt an amendment to comply with the $2,500 limit on or before

Continue on page 3 | **Health FSA**

Health FSA | Continued from page 2

December 31, 2014. An amendment to comply with the limit that is adopted on or before December 31, 2014 may be effective retroactive to the first day of the 2013 plan year, if the cafeteria plan operates in accordance with the $2,500 limit for plan years beginning after December 31, 2012.

The Notice also provides that the Treasury Department and the IRS are considering whether the "use-it-or-lose-it" rule should be modified for Health FSAs. The $2,500 limit under PPACA reduces the (1) potential for using a Health FSA to defer compensation, and (2) extent to which salary reduction amounts may accumulate over time. The Treasury Department and IRS are accepting comments until August 17, 2012 regarding whether the use-it-or-lose-it rule should be modified, including how any modifications would interact with the $2,500 limit.

Please contact your Foster Swift employee benefits professional with any questions.

Lauren B. Dunn
Attorney
P: 571.371.8324
E: ldunn@fosterswift.com

WAIVER OF THE 60-DAY ROLLOVER PERIOD

- Jaxine L. Wintjen

A participant who misses the 60-day rollover window may be eligible for an automatic waiver of the 60-day rollover rule if all of the following five requirements are met:

1. The financial institution receives the funds on the participant's behalf before the end of the 60-day rollover period.
2. The participant followed all of the procedures set by the financial institution for depositing the funds into an eligible retirement plan (including an IRA) within the 60-day rollover period (including giving instructions to deposit the funds into an eligible retirement plan).
3. The funds are not deposited into an eligible retirement plan within the 60-day rollover period solely because of an error on the part of the financial institution.
4. The funds are deposited into an eligible retirement plan within one year from the beginning of the 60-day rollover period.
5. The deposit would have been a valid rollover if the financial institution had deposited the funds as instructed.

In addition to the automatic waiver of the rollover period discussed above, the IRS may grant a waiver of the 60-day rollover rule upon submission of a ruling request, along with the applicable user fee. The amount of the user fee is based on the amount of the rollover as set forth in the chart below.

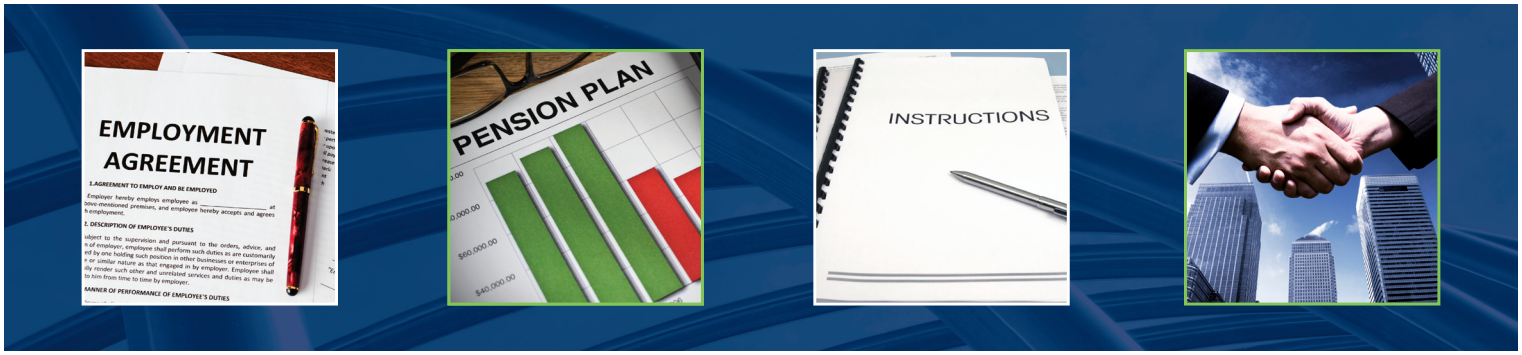
Amount of Rollover	Applicable User Fee
Less than $50,000	$500
$50,000 but less than $100,000	$1,500
$100,000 or more	$3,000

The IRS will consider all of the relevant facts and circumstances when considering whether to grant the request including:

1. Whether errors were made by the financial institution (in addition to those described under the automatic waiver discussed above).
2. Whether the participant was unable to complete the rollover due to death, disability, hospitalization, incarceration, restrictions imposed by a foreign country or postal errors.
3. Whether the participant used the amount distributed (for example, in the case of payment by check, whether the check was cashed).
4. The amount of time that has elapsed since the date of distribution.

Only IRA owners, plan participants and surviving spouses are eligible to receive a waiver under this procedure. Non-spouse beneficiaries will not receive an extension of the 60-day rollover period.

Jaxine L. Wintjen
Paralegal
P: 571.371.8267
E: jwintjen@fosterswift.com



Employment, Labor & Benefits Quarterly

SERVICE PROVIDER FEE DISCLOSURE FINAL REGULATION AND PARTICIPANT LEVEL FEE DISCLOSURE FINAL REGULATION

- Lauren B. Dunn

The U.S. Department of Labor ("DOL") published the final Service Provider Fee Disclosure Regulation (the "Final Regulation") on February 3, 2012. The Final Regulation requires that certain retirement plan vendors who supply services to a "covered plan" (generally, an ERISA employee benefit plan) disclose certain information to the employer sponsor with regard to the compensation that is received by the vendor for the performance of those services. The Final Regulation effective date is July 1, 2012 (the " Effective Date").

The Effective Date also affects the date when a plan sponsor must make initial disclosures of certain fee information to retirement plan participants under the final Participant Level Fee Disclosure Regulation (the "Participant Level Fee Disclosure Regulation"). Because of the Effective Date, initial disclosures under the Participant Level Fee Disclosure Regulation for a calendar year plan must be furnished to plan participants not later than August 30, 2012. Plan sponsors of calendar year plans must also furnish the first required quarterly disclosure to plan participants not later than November 14, 2012.

FOSTER SWIFT NAMED "2012 TOP RANKED LAW FIRM" BY MARTINDALE-HUBBELL

Foster Swift was named a "2012 Top Ranked Law Firm" by Martindale Hubbell® in *Fortune* Magazine. The list of Top Ranked Law Firms features US law firms with 21 or more attorneys in which at least 1 in 3 of their lawyers earned the AV® Preeminent™ Peer Review Rating. Currently, Foster Swift has 46 attorneys with an "AV Rating." To put this in perspective, of the 254,000 law firms rated by Martindale-Hubbell, only 1000 firms have achieved this elite status.

FOSTER SWIFT EARNS TOP HONORS FROM LOCAL VOTERS

Foster Swift was voted number one for Best Services Lawyer in the 2012 Top of the Town Awards. Each year, the community newspaper, *Lansing City Pulse* sponsors this survey that recognizes individuals and businesses who are essential to making the Lansing area a great place to live, work, play, raise a family and do business. This accolade appeared in *Lansing City Pulse*.

EMPLOYMENT, LABOR & BENEFITS:

PRACTICE GROUP LEADER

Stephen J. Lowney
517.371.8272
slowney@fosterswift.com

ATTORNEYS:

Michael R. Blum | 248.785.4722
Lauren B. Dunn | 517.371.8324
Joel C. Farrar | 517.371.8305
Matt G. Hrebec | 517.371.8256
Erica E. L. Huddas | 517.371.8138
Melissa J. Jackson | 517.371.8106
Stephen I. Jurmu | 517.371.8260
Frank T. Mamat | 248.539.9919
Robert E. McFarland | 248.539.9901
Johanna M. Novak | 906.226.5501
Sherry A. Stein | 517.371.8269

PARALEGALS:

Terri L. Bolyard | 517.371.8234
Jaxine L. Wintjen | 517.371.8267