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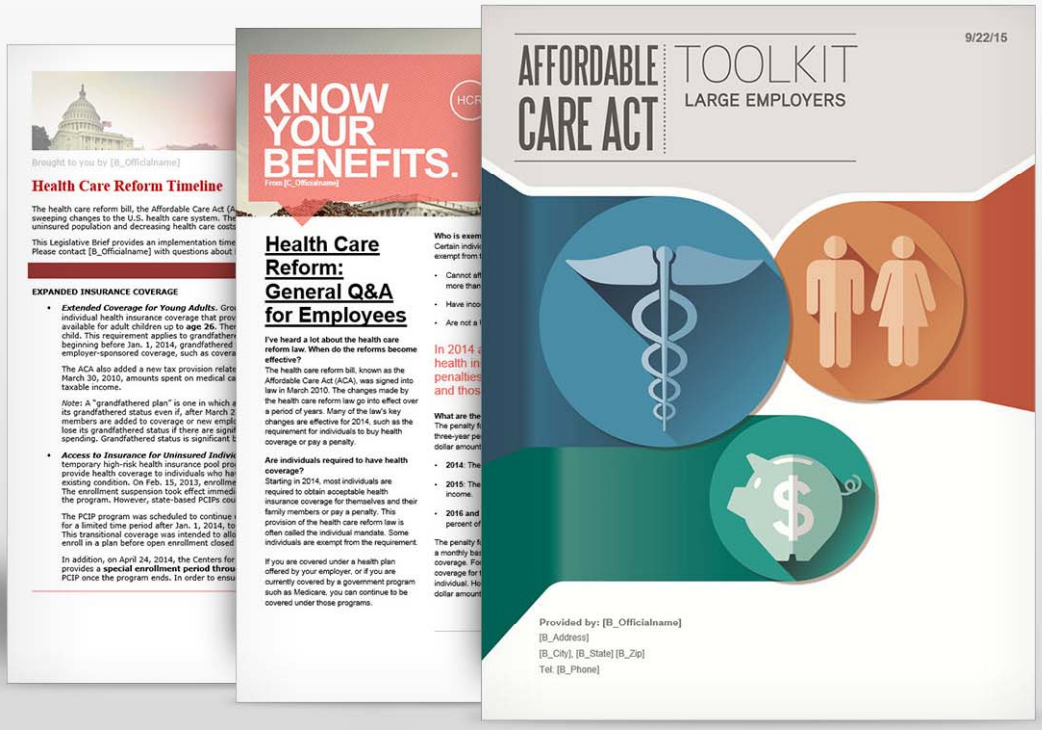
Your Health Care Reform Partner



Are you in compliance with health care reform regulations?

We can help you stay on top of health care reform in order to avoid penalties—from legislative briefs to compliance checklists, we've got you covered.

How do you keep employees aware of changes?

Our employee communications materials will help employees understand how reform changes affect them and their families.

Do you have unanswered questions about health care reform?

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Sample Documents

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Health Care Reform Timeline

The health care reform bill, the Affordable Care Act (ACA), was signed into law on March 23, 2010. The ACA makes sweeping changes to the U.S. health care system. The ACA's health care reforms, which are focused on reducing the uninsured population and decreasing health care costs, are being implemented over a period of several years.

This Legislative Brief provides an implementation timeline of key ACA reforms that affect employers and individuals. Please contact 5GBenefits.com LLC with questions about how you can prepare for the health care reform requirements.

2010

EXPANDED INSURANCE COVERAGE

- ***Extended Coverage for Young Adults***. Group health plans and health insurance issuers offering group or individual health insurance coverage that provide dependent coverage of children must make coverage available for adult children up to **age 26**. There is no requirement to cover the child or spouse of a dependent child. This requirement applies to grandfathered and non-grandfathered plans. However, for plan years beginning before Jan. 1, 2014, grandfathered plans need not cover adult children who are eligible for other employer-sponsored coverage, such as coverage through their own employer.

  The ACA also added a new tax provision related to health insurance coverage for these adult children. As of March 30, 2010, amounts spent on medical care for an eligible adult child can generally be excluded from taxable income.

  Note: A "grandfathered plan" is one in which an individual was enrolled on March 23, 2010. A plan will retain its grandfathered status even if, after March 23, 2010, covered individuals renew their coverage, family members are added to coverage or new employees (and their families) enroll for coverage. A health plan will lose its grandfathered status if there are significant cuts to benefits or increases in participants' out-of-pocket spending. Grandfathered status is significant because many ACA reforms do not apply to grandfathered plans.

- ***Access to Insurance for Uninsured Individuals with Pre-existing Conditions***. The ACA created a temporary high-risk health insurance pool program, called the Pre-existing Condition Insurance Plan (PCIP), to provide health coverage to individuals who have been uninsured for at least six months because of a pre-existing condition. On Feb. 15, 2013, enrollment in the PCIP program was suspended due to limited funding. The enrollment suspension took effect immediately in 23 states where the federal government administered the program. However, state-based PCIPs could accept enrollment applications through March 2, 2013.

  The PCIP program was scheduled to continue until **Jan. 1, 2014**. However, HHS offered transitional coverage for a limited time period after Jan. 1, 2014, to PCIP enrollees who had not yet secured other health insurance. This transitional coverage was intended to allow PCIP enrollees more time to review Exchange options and enroll in a plan before open enrollment closed on March 31, 2014. See www.pcip.gov for more information.

- In addition, on April 24, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a bulletin that provides a **special enrollment period through the Exchange** for individuals who lose coverage through the PCIP once the program ends. In order to ensure that eligible individuals who are losing coverage through PCIP

  because the program ended can avoid a lapse in coverage, CMS is providing a special enrollment period for enrollment in a qualified health plan (QHP) offered through the FFE in 2014. According to CMS, state-based Exchanges are adopting a similar special enrollment period.

- ***Identifying Affordable Coverage***. HHS established an Internet website—www.healthcare.gov—through which residents of any state may identify affordable health insurance coverage options in their state. The website also includes information for small businesses about available coverage options, reinsurance for early retirees, small business tax credits and other information of interest to small businesses. So-called "mini-med" or limited-benefit plans were precluded from listing their policies on this website.

- ***Reinsurance for Covering Early Retirees***. The ACA established a temporary reinsurance program to reimburse participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees and their spouses, surviving spouses and dependents. This program was designed to end on Jan. 1, 2014, or earlier, if the $5 billion in funding was exhausted. Due the program's popularity and rapid use of funding, it stopped accepting applications as of May 5, 2011 and did not reimburse claims incurred after Dec. 31, 2011. The deadline for submitting ERRP reimbursement requests was July 31, 2013.

HEALTH INSURANCE REFORM

- ***Eliminating Pre-existing Condition Exclusions for Children***. Group health plans and health insurance issuers may not impose pre-existing condition exclusions on coverage for children under age 19. This provision applies to all employer plans and non-grandfathered plans in the individual market. This provision also applies to all enrollees effective for plan years beginning on or after Jan. 1, 2014.

- ***Coverage of Preventive Care Services***. Group health plans and health insurance issuers offering group or individual health insurance coverage must cover certain preventive care services without cost-sharing (for example, deductibles, copayments or coinsurance). Grandfathered plans are exempt from this requirement.

- ***Prohibiting Rescissions***. The ACA prohibits rescissions, or retroactive cancellations, of coverage, except in cases of fraud or intentional misrepresentation. Also, plans and issuers must provide at least 30 days' advance notice to the enrollee before coverage may be rescinded. This provision applies to all grandfathered and non-grandfathered plans.

- ***Lifetime and Annual Limits***. Group health plans and health insurance issuers offering group or individual health insurance coverage may not impose lifetime limits or unreasonable annual limits on the dollar value of essential health benefits. This requirement applies to all plans, although plans were allowed to request a waiver of the annual limit requirement for plan years beginning before Jan. 1, 2014. The annual limit waiver program closed to applications on Sept. 22, 2011. All annual dollar limits on essential health benefits are prohibited for plan years beginning on or after Jan. 1, 2014.

HEALTH PLAN ADMINISTRATION

- ***Improved Claims and Appeals Process***. Group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective process for benefit claims and appeals of coverage determinations. A plan's or issuer's internal claims and appeals process must comply with the claims procedure regulation issued by the Department of Labor (DOL) in 2001. In addition, the ACA requires plans and issuers to:

  - Have an internal claims and appeals process in effect that provides claimants with a full and fair review;

- Provide information to claimants in a culturally and linguistically appropriate manner in some situations;

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2016 Compliance Checklist

The Affordable Care Act (ACA) has made a number of significant changes to group health plans since the law was enacted over four years ago. Many of these key reforms became effective in 2014 and 2015, including health plan design changes, increased wellness program incentives and the employer shared responsibility penalties.

Additional reforms take effect in 2016 for employers sponsoring group health plans. To prepare for 2016, employers should review upcoming requirements and develop a compliance strategy.

This Legislative Brief provides a health care reform compliance checklist for 2016. Please contact 5GBenefits.com LLC for assistance or if you have questions about changes that were required in previous years.

PLAN DESIGN CHANGES

Grandfathered Plan Status

A grandfathered plan is one that was already in existence when the ACA was enacted on March 23, 2010. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact 5GBenefits.com LLC if you have questions about changes you have made, or are considering making, to your plan.

Review your plan's grandfathered status:

- ☐ If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2016 plan year. Grandfathered plans are exempt from some of the ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year.
- ☐ If your plan will lose its grandfathered status for 2016, confirm that the plan has all of the additional patient rights and benefits required by the ACA for non-grandfathered plans. This includes, for example, coverage of preventive care without cost-sharing requirements.
- ☐ If your plan will keep grandfathered status, continue to provide the Notice of Grandfathered Status in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan (such as the plan's summary plan description and open enrollment materials). Model language is available.

Cost-sharing Limits

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are subject to limits on cost-sharing for essential health benefits (EHB). The ACA's overall annual limit (or an out-of-pocket maximum) applies for all non-grandfathered group health plans, including self-insured health plans and insured plans.

Under the ACA, a health plan's out-of-pocket maximum for EHB may not exceed **$6,850** for self-only coverage and **$13,700** for family coverage, effective for plan years beginning on or after Jan. 1, 2016.

Health plans with more than one service provider may divide the out-of-pocket maximum across multiple categories of benefits, rather than reconcile claims across multiple service providers. Thus, health plans and issuers may structure a benefit design using separate out-of-pocket maximums for EHB, provided that the combined amount does not exceed the annual out-of-pocket maximum limit for that year. For example, in 2016, a health plan's self-only coverage may have an out-of-pocket maximum of $5,000 for major medical coverage and $1,850 for pharmaceutical coverage, for a combined out-of-pocket maximum of $6,850.

However, effective for the 2016 plan year, the Department of Health and Human Services (HHS) clarified that **the self-only annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage**. This guidance embeds an individual out-of-pocket maximum in family coverage so that an individual's cost-sharing for essential health benefits cannot exceed the ACA's out-of-pocket maximum for self-only coverage.

Note that the ACA's cost-sharing limit is higher than the out-of-pocket maximum for high-deductible health plans (HDHPs). In order for a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum limit for HDHPs. In an FAQ, HHS provides guidance on how this ACA rule affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage.

According to HHS, an HDHP that has a $10,000 family deductible must apply the annual limitation on cost-sharing for self-only coverage ($6,850 in 2016) to each individual in the plan, even if this amount is below the $10,000 family deductible limit. Because the $6,850 self-only maximum limitation on cost-sharing exceeds the 2016 minimum annual deductible amount for HDHPs ($2,600), it will not cause a plan to fail to satisfy the requirements for a family HDHP.

Check your plan's cost-sharing limits:

- ☐ Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2016 plan year ($6,850 for self-only coverage and $13,700 for family coverage).
- ☐ If you have an HDHP that is compatible with a health savings account (HSA), keep in mind that your plan's out-of-pocket maximum must be lower than the ACA's limit. For 2016, the out-of-pocket maximum limit for HDHPs is **$6,550** for self-only coverage and **$13,100** for family coverage.
- ☐ If your plan uses multiple service providers to administer benefits, confirm that the plan will coordinate all claims for EHB across the plan's service providers, or will divide the out-of-pocket maximum across the categories of benefits, with a combined limit that does not exceed the maximum for 2016.
- ☐ Confirm that the plan applies the self-only maximum to each individual in the plan, regardless of whether the individual is enrolled in self-only coverage or family coverage.

Health FSA Contributions

Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) must be limited to $2,500. The $2,500 limit does not apply to employer contributions to the health FSA, and does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

On Oct. 31, 2013, the Internal Revenue Service (IRS) announced that the health FSA limit remained unchanged at $2,500 for the taxable years beginning in 2014. However, the $2,500 limit is expected to be indexed for cost-of-living adjustments for later years. The IRS is expected to release the health FSA limit for 2015 later this year.

AFFORDABLE CARE ACT | TOOLKIT

SMALL EMPLOYERS

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Employer Reporting of Health Coverage—Code Sections 6055 & 6056

The Affordable Care Act (ACA) created new reporting requirements under Internal Revenue Code (Code) Sections 6055 and 6056. Under these new reporting rules, certain employers must provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees. The additional reporting is intended to promote transparency with respect to health plan coverage and costs. It will also provide the government with information to administer other ACA mandates, such as the large employer shared responsibility penalty and the individual mandate.

OVERVIEW

TYPE OF REPORTING	AFFECTED EMPLOYERS	REQUIRED INFORMATION	EFFECTIVE DATE
Code §6055—Reporting of health coverage by health insurance issuers and sponsors of self-insured plans	Employers with self-insured health plans	Information on each individual provided with coverage (helps the IRS administer the ACA's individual mandate)	**Delayed until 2015** The first returns will be due in 2016 for coverage provided in 2015
Code §6056—Applicable large employer (ALE) health coverage reporting	Applicable large employers (those with at least 50 full-time employees, including full-time equivalents)	Terms and conditions of health plan coverage offered to full-time employees (helps the IRS administer the ACA's employer shared responsibility penalty)	

Guidance

On March 5, 2014, the Internal Revenue Service (IRS) released **two final rules** on these reporting requirements, which apply for calendar years beginning after **Dec. 31, 2014**. This date reflects a one-year delay provided in IRS Notice 2013-45. However, the IRS is encouraging voluntary compliance for 2014. The IRS also released Q&As on Section 6055 and Q&As on Section 6056, which were updated in May 2015. In addition, the IRS released a separate set of Q&As on Employer Reporting using Form 1094-C and Form 1095-C, on May 28, 2015.

On Feb. 8, 2015, the IRS released **final versions of forms and instructions** that employers will use to report under Sections 6055 and 6056 for 2014. **These forms are not required to be filed for 2014**, but reporting entities may voluntarily file them in 2015 for 2014 coverage.

On Sept. 17, 2015, the IRS released the following **final 2015 versions of the forms and instructions** that employers will use to report under Sections 6055 and 6056. On the same day, the IRS issued Notice 2015-68 to provide additional guidance for purposes of Section 6055 reporting.

- Form 1094-B and Form 1095-B (and related instructions) will be used by entities reporting under **Section 6055**, including sponsors of self-insured group health plans that are not reporting as ALEs.
- Form 1094-C and Form 1095-C (and related instructions) will be used by ALEs that are reporting under **Section 6056**, and for combined reporting by ALEs that sponsor self-insured plans required to report under both Sections 6055 and 6056.

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This Toolkit is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. The contents of this document may be affected by future regulations and sub-regulatory guidance.

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Pay or Play Penalty—Offer of Coverage

The Affordable Care Act (ACA) imposes a penalty on applicable large employers (ALEs) that do not offer health insurance coverage to substantially all full-time employees and dependents. Penalties may also be imposed if coverage is offered, but is unaffordable or does not provide minimum value. The ACA's employer penalty rules are often referred to as "employer shared responsibility" or "pay or play" rules.

> The employer penalty provisions were set to take effect on Jan. 1, 2014. However, in July 2013, the Treasury announced that **the employer penalties and related reporting requirements would be delayed for one year, until 2015.** Therefore, no penalties will apply to any employers for 2014. Smaller ALEs may also be eligible for an additional one-year delay.

On Feb. 12, 2014, the Internal Revenue Service (IRS) published **final regulations** on the employer shared responsibility rules. These regulations finalize provisions in proposed regulations released on Jan. 2, 2013. Under the final regulations, **ALEs that have fewer than 100 full-time employees (including full-time equivalents, or FTEs) generally will have an additional year, until 2016, to comply with the pay or play rules.** ALEs with 100 or more full-time employees (including FTEs) must comply with the pay or play rules starting in 2015.

The employer shared responsibility rules impose specific requirements on the "offer of coverage" that an ALE must provide to its full-time employees (and dependents). This Legislative Brief provides an overview of the requirements related to the ALE's offer of coverage.

OVERVIEW OF EMPLOYER PENALTIES

Beginning in 2015, an ALE may be subject to a penalty if it:

- Fails to offer to substantially all full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for any month; or
- Offers eligible employer-sponsored coverage that is not affordable or does not provide minimum value.

An ALE is an employer with, on average, **at least 50 full-time employees, including FTEs**, during the preceding calendar year. Full-time employees are those working an average of **30 or more hours per week** (or 130 hours in a calendar month).

Regardless of whether or not an ALE offers coverage, a penalty will be assessed ***only if*** at least one of its full-time employees receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Beginning in 2014, low-income individuals who are not offered employer-sponsored coverage and who are not eligible for Medicaid or other programs may be eligible for premium tax credits or cost-sharing reductions for coverage purchased through an Exchange.

The final rules **delay implementation for ALEs that have fewer than 100 full-time employees** (including FTEs). These medium-sized ALEs will generally have an additional year, until 2016, to comply with the pay or play rules. However, an ALE must certify that it meets certain eligibility conditions to qualify for this delay.

Pay or Play Penalty – Offer of Coverage

OFFER OF COVERAGE

In general, the employer shared responsibility rules require an ALE to offer an effective opportunity to accept coverage **at least once during the plan year**. If an employee has not been offered an effective opportunity to accept coverage, the employee will not be treated as having been offered the coverage for purposes of the employer shared responsibility provision.

The employee must also have, at least once during the plan year, an effective opportunity to decline an offer of coverage that is not minimum value coverage or that is not affordable. However, an effective opportunity to decline is not required for an offer of coverage that provides minimum value and is either:

- Affordable (determined based on the federal poverty level safe harbor); or
- No cost to the employee.

Thus, an employer may not render an employee ineligible for subsidized coverage by providing an employee with mandatory coverage (that is, coverage which the employee is not offered an effective opportunity to decline) that does not meet minimum value. The final regulations also clarify that an employee's election of coverage from a prior year that continues for every succeeding plan year unless the employee affirmatively elects to opt out of the plan constitutes an offer of coverage for purposes of the employer shared responsibility rules.

For an employee to be treated as having been offered coverage for a month (or any day in that month), the coverage offered, if accepted, must be applicable for that month (or that day). If an ALE fails to offer coverage to a full-time employee for any day of a calendar month during which the employee was employed, the employee is treated as not being offered coverage during that entire month. However, a full-time employee who terminates employment in a calendar month will be treated as having been offered coverage during that month as long as the employee would have been offered coverage for the entire month if he or she had been employed for the entire month.

If an employee enrolls in coverage but **fails to pay his or her share of the premium on a timely basis**, the employer is not required to provide coverage for the period for which the premium is not paid in a timely fashion, but will still be treated as having offered that employee coverage for the remainder of the coverage period (typically the remainder of the plan year) for purposes of the employer shared responsibility rules.

Minimum Essential Coverage

For purposes of the employer shared responsibility rules, an ALE is not treated as having offered coverage to an employee unless the coverage qualifies as **"minimum essential coverage"** (MEC). The definition of MEC under the ACA is very broad, and includes coverage under an eligible employer-sponsored plan. An eligible employer-sponsored plan is, with respect to any employee:

- Group health insurance coverage offered by (or on behalf of) an employer to the employee that is either:
  - A governmental plan;
  - Any other plan or coverage offered in the small or large group market within a state; or
  - A grandfathered health plan offered in a group market; or
- A self-insured group health plan under which coverage is offered by (or on behalf of) an employer to the employee.

In general, most employer-sponsored coverage will qualify as MEC. However, MEC does not include coverage consisting solely of excepted benefits (as defined by HIPAA). MEC also does not include specialized coverage, such as coverage only for vision or dental care, workers' compensation, disability policies or coverage only for a specific disease or conditions.

Health Care Reform: Who, What, When

Timeline of health care changes

Here is a look at some of the major health care reform provisions that you will see over the next decade.

2010

Employers: Small businesses can receive tax credits if purchasing insurance for employees.

Insurers: Cannot impose pre-existing condition exclusions on coverage for children. Must cover preventive services without copays. Cannot remove coverage when a person becomes ill. Cannot impose lifetime coverage limits. Health care reform also regulates annual limits. Insurers must provide an improved way for consumers to appeal health care decisions.

Uninsured: Individuals with pre-existing conditions receive immediate access to coverage through a high-risk pool. Dependent children can remain on parents' plans until age 26. States will be allowed to cover more people on Medicaid.

Early retirees: Employers were able to participate in a reinsurance program to help provide coverage for retirees and their spouses, surviving spouses and dependents over age 55 and not eligible for Medicare. Due to funding limits, this program stopped reimbursements for claims incurred after Dec. 31, 2011.

Medicare Part D enrollees: A $250 rebate check received for those entering the "donut hole" gap in coverage in 2010. Rebate payable by April 1, 2011.

2011

Insurers: Required to spend at least 80 to 85 percent of premiums on medical services.

Medicare Part D enrollees: Receive a 50 percent discount on brand-name prescription drugs when in donut hole coverage gap.

Health care savings account holders: Federal tax on those who spend health care savings account money on ineligible expenses increases to 20 percent.

Over-the-counter drugs: Except for insulin, OTC drugs without a prescription are not reimbursable from an FSA or HRA, and are not a tax-free reimbursement from an HSA.

W-2: The value of employees' health coverage must be disclosed on their W-2 forms (optional for 2011 for all employers, large employers must comply in 2012).

Health Care Reform: General Q&A for Employees

I've heard a lot about the health care reform law. When do the reforms become effective?
The health care reform bill, known as the Affordable Care Act (ACA), was signed into law in March 2010. The changes made by the health care reform law go into effect over a period of years. Many of the law's key changes are effective for 2014, such as the requirement for individuals to buy health coverage or pay a penalty.

Are individuals required to have health coverage?
Starting in 2014, most individuals are required to obtain acceptable health insurance coverage for themselves and their family members or pay a penalty. This provision of the health care reform law is often called the individual mandate. Some individuals are exempt from the requirement.

If you are covered under a health plan offered by your employer, or if you are currently covered by a government program such as Medicare, you can continue to be covered under those programs.

Who is exempt from the individual mandate?
Certain individuals are exempt from the individual mandate. For example, you may be exempt from the penalty for not maintaining acceptable health coverage if you:

- Cannot afford coverage (that is, the required contribution for coverage would cost more than 8 percent of your household income)
- Have income below the federal income tax filing threshold
- Are not a U.S. citizen or national, or are not lawfully present in the United States

In 2014 and after, most U.S. citizens must obtain health insurance coverage or they will be subject to penalties, with exceptions for low-income individuals and those unable to obtain affordable coverage.

What are the penalties for individuals who don't have health coverage?
The penalty for not obtaining acceptable health coverage will be phased in over a three-year period. The amount of the penalty is the greater of two amounts: the "flat dollar amount" and the "percentage of income amount."

2014: The annual penalty will start at $95 per person or up to 1 percent of income.

2015: The annual penalty increases to $325 per person or up to 2 percent of income.

2016 and after: The annual penalty increases to $695 per person or up to 2.5 percent of income.

The penalty for a child is half of that for an adult. The annual penalty is calculated on a monthly basis, and is assessed for each month in which an individual goes without coverage. For example, if the flat dollar amount applies and a person goes without coverage for the entire year in 2015, the annual penalty amount will be $325 for that individual. However, if the individual has coverage for part of the year in 2015, the flat dollar amount penalty will be 1/12 of $325 for each month without coverage.

Health Care Reform Large Employer Calculator
Health Care Reform Full-time Employee Tracker

SIMPLIFY THE COMPLEX →

New health care reform calculators now available

ACA Tools

Under the Affordable Care Act's (ACA) employer mandate, large employers may be subject to a penalty tax if they do not offer health care coverage to all full-time employees (and their dependents). These employers may also be subject to a penalty if they offer coverage that is unaffordable or does not provide minimum value. These employers will also have to report certain information to the IRS about the health coverage they offer to their employees.

The employer penalty rules and related reporting requirements are complex and can be difficult to navigate. 5GBenefits.com LLC can help you handle some of the more confusing questions.

Are You a Large Employer?

The first question you have to answer when evaluating your exposure to the ACA's employer penalties is whether you qualify as a large employer. Large employer status is based on employee count during the prior calendar year and includes special rules for part-time and seasonal employees.

Our **Large Employer Calculator** provides you with a way to calculate your large employer status in order to help you determine if your company could be subject to penalties if you don't offer appropriate coverage to your full-time employees and their dependents.

Figuring Out Full-Time Employees

Once you confirm that your company will be considered a large employer, you need to decide whether to "pay or play." That is, pay the penalties or offer sufficient coverage to your full-time employees to avoid them.

In many cases, it can be difficult to predict whether someone will work the 30 hours of service per week to be full time under the new rules. The IRS has offered a way for employers to measure employee hours of service (and then treat them as full time or not) that will allow employers to avoid penalties for variable hour employees.

This method is complicated and brand new, so employers can find it confusing. Our **Full-Time Employee Tracker** gives you a way to simplify this process and document the method you are using to determine whether your employees are full time employees eligible for health coverage.

Reporting to the IRS

All employers that are subject to the employer mandate will have to report certain information to the IRS about the health coverage they offer to their employees. Also, employers that offer self-insured coverage will have to provide additional information.

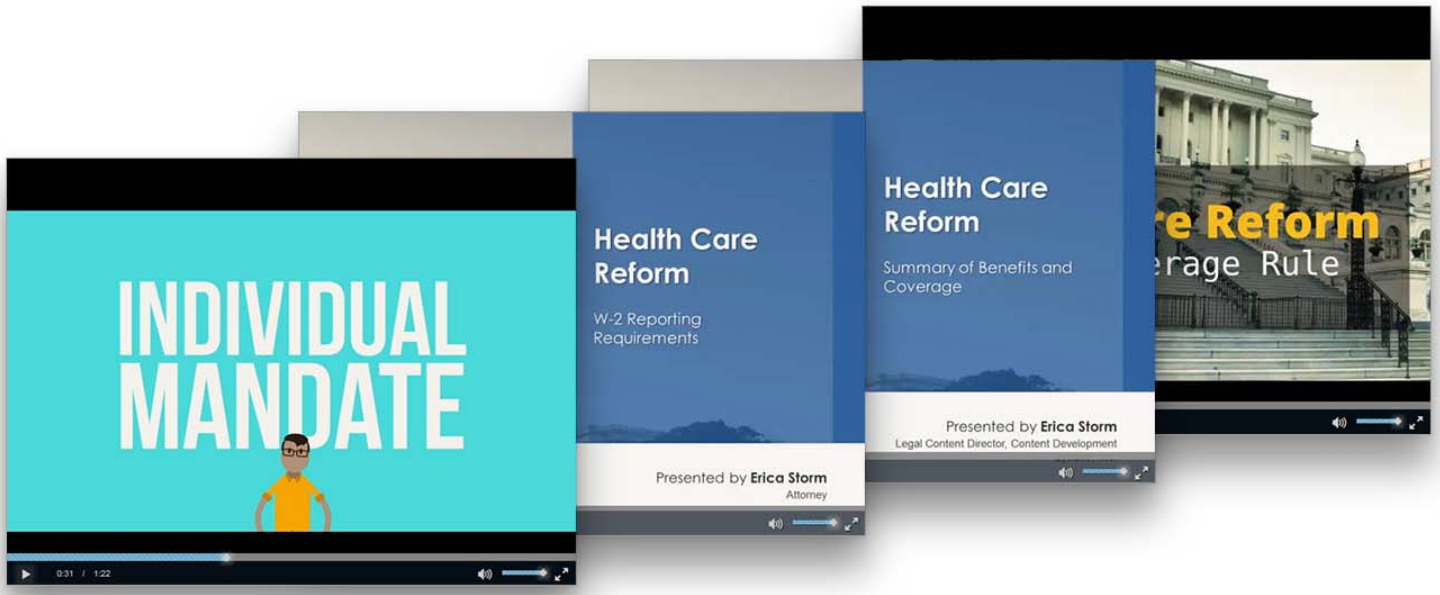
Our **Section 6055 and Section 6056 Reporting Workbooks** will guide you through each step of the reporting process to help you track the information you need to be in compliance.

Contact Us!

5GBenefits.com LLC is committed to being your trusted resource for all things related to health care reform.

For more information please contact :
Tony Goebel
Owner/Benefits Advisor at 6Gbenefits, LLC

Video Content



Employer Videos

Health Care Reform: W-2 Reporting Requirements This video gives the details of the health care reform's W-2 reporting requirement, what its purpose is and what it means for you as an employer.

Health Care Reform: Summary of Benefits and Coverage This video explains the health care reform's disclosure requirement, the Summary of Benefits and Coverage, and how to ensure that you are in compliance with it.

Employee Videos

Health Care Reform: Age 26 Coverage Rule This video discusses health care reform's extension of dependent coverage to age 26, focusing on eligibility and coverage requirements.

Health Care Reform: Fees This video discusses the specifics of three new fees placed on health insurance issuers and health plan sponsors as part of the Affordable Care Act. These fees are: The Patient-Centered Outcomes Research Institute fee, or the PCORI fee; The Reinsurance fee; and The Health Insurance Providers fee.