



# Helping Your Employees **Connect to Good Health**

## Section 125 Plan Handbook for Employers



Commonwealth**Connector**

Version 1.0 (April 23, 2007)

This handbook can also be found on the Health Connector's website at [www.MAhealthconnector.org](http://www.MAhealthconnector.org)

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## I. Introduction

The goal of the Mass Health Care Reform Law is to increase access to medical (health) care coverage for residents of the Commonwealth. The guiding principle behind this reform is one of shared responsibility: individuals, employers, health plans and state agencies all have new responsibilities under the law.

One of the primary employer responsibilities under the Mass Health Care Reform Law is the requirement that employers with 11 or more full-time equivalent employees adopt and maintain a Plan that satisfies both a) Section 125 of the Internal Revenue Code and b) regulations established by the Commonwealth Connector (the Health Connector). This requirement goes into effect on July 1, 2007.

The purpose of this handbook is to explain and help employers comply with these new requirements. We recommend that employers consult with their broker, consultant and/or attorney before adopting or amending their Section 125 Plan (Plan) to meet these requirements.

### Following are some highlights of the new requirements:

- The Plan must be, at minimum, a “premium-only plan” that allows employees to pay for or contribute to the cost of health care coverage on a pre-tax basis.
- The Plan must offer eligible employees access to one or more health care coverage options.
- Employers do not need to contribute to the cost of health care coverage options available under the Plan.
- While health care coverage options made available under the employer’s Plan don’t need to include those offered through the Health Connector, there are several advantages to doing so. These include:
  - Employees may select from several affordable Commonwealth Choice health coverage options offered by Blue Cross Blue Shield of Mass, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan
  - All Commonwealth Choice options have earned the Health Connector’s Seal of Approval and comply with the Mass Health Reform Law
  - It’s easy for members to enroll in Commonwealth Choice
  - The Commonwealth Choice premium billing process is streamlined for the employer
- Employers may exclude certain classes of employees from the Plan.
- A copy of the Plan must be filed with the Health Connector (information on how an employer can meet this requirement will be available on the Health Connector’s website at a later date).

The Section 125 Plan requirements are explained in more detail in the following sections of this Handbook. Employers who meet these requirements are exempt from the Free Rider Surcharge provision of the Mass Health Care Reform Law.

## II. What is a Section 125 Plan?

Under federal tax law, a Section 125 Plan is a written plan that permits employees to choose between receiving cash (the employee's normal cash wages) and certain qualified benefits that can be paid for on a pre-tax basis by employees.

A Section 125 Plan may be established by any of the following:

- C Corporations
- Partnerships
- S Corporations
- Limited Liability Corporations
- Sole Proprietorships
- Professional Corporations
- Non-Profit Organizations

IRS regulations state that self-employed individuals are not employees. Therefore, self-employed individuals may establish but may not participate in a Section 125 Plan, although spouses or other family members who are employees may participate in some cases.

A Section 125 "premium-only plan" allows employees to pay their health care coverage premiums on a pre-tax basis, thus lowering their taxable income and, consequently, their tax liability.

An employee's election to pay for benefits on a pre-tax basis is made by entering into a salary reduction agreement with the employer. Under a salary reduction agreement, an employee elects to reduce his/her compensation by a stated amount on a pre-tax basis and those amounts are considered by the IRS to be employer contributions. In effect, it is as if the employee has given up the right to receive that part of his/her salary before actually becoming entitled to it. Therefore, the employee's salary reduction contributions are not actually received by the employee, and thus, are neither considered wages for state and federal income tax purposes nor subject to FICA withholding.

*It is important to note that, under a Section 125 Plan, health care coverage premiums may be paid entirely by employee salary reduction – employer contributions are not required.*

### III. What are the Benefits of a Section 125 Plan?

There are several benefits to maintaining a Section 125 Plan:

#### Pre-tax savings for the employer and its employees

As mentioned above, an employee who pays his/her health care coverage premiums on a pre-tax basis realizes a savings on state income, federal income and federal FICA taxes. This tax savings could amount to as much as 40% of the cost of health care coverage. The employer also realizes FICA withholding tax savings for each participating employee.

The example below illustrates the annual tax savings realized by an employee in Massachusetts with adjusted gross income of \$50,000 who participates in his/her employer's Plan:

	<b>w/o Plan</b>	<b>with Plan</b>
Adjusted Gross Income	\$50,000	\$50,000
Annual Pre-tax Health Care Coverage Contribution	\$0	\$ 2,100
Taxable Income	\$50,000	\$47,900
Estimated Taxes	\$12,676	\$11,880
Annual After-Tax Health Care Coverage Contribution	\$ 2,100	\$0
Net Take Home Pay	\$ 35,224	\$36,020

In this example, the employee achieves annual tax savings of \$796 and his/her employer saves \$161 in annual FICA taxes.

#### Increased Morale

Allowing employees to pay their health care coverage premiums on a pre-tax basis increases their take-home pay, effectively giving them a pay raise with no added costs to their employer. Any pay raise is appreciated by employees, whose boosted morale can increase productivity.

#### Avoidance of Free Rider Surcharge

Under the Mass Health Care Reform Law, the Free Rider Surcharge is a penalty that may be charged to employers who do not comply with the Section 125 Plan requirement. Additional information on the Free Rider Surcharge may be found on the Health Connector's website at [www.MAhealthconnector.org](http://www.MAhealthconnector.org).

## IV. How to Meet Federal and State Section 125 Plan Requirements

Employers with 11 or more full-time equivalent employees are required to adopt and maintain a Section 125 Plan that meets the requirements of both federal law and Mass Health Care Reform law (and subsequent regulations published by the Health Connector).

### Requirements under Federal Law

Section 125 of the Internal Revenue Code requires a written Plan Document that must be adopted by the employer on or before the date the Plan is effective.

The Plan Document must contain the following:

- Description of the benefits that may be elected
- Eligibility rules
- Method, timing and irrevocability of participant elections
- Manner of any employer contribution
- Maximum amount of employer and employee contributions under the plan
- The Plan Year

Federal law does not contain any specifics about how to adopt a Plan. Employers that are corporations should adopt the Plan by a resolution of its board of directors (or an authorized representative of the board). Other types of employers may use a certificate of adoption. Once adopted, the written Plan Document is usually signed by an officer or other individual who has authority to sign benefit plan documents.

There is no requirement to file the Plan Document with the IRS or any other federal agency. Additionally, the IRS currently does not issue rulings or determination letters indicating whether an employer's Plan satisfies the federal Section 125 Cafeteria Plan requirements.

### Requirements under State Law and Connector Regulations

For purposes of Mass Health Care Reform, the Health Connector regulations provide that a Section 125 Plan must be, at minimum, a premium-only plan offering access to one or more health coverage options in lieu of regular cash compensation. It must meet federal requirements as outlined above. It need not follow a particular Plan Year.

Section 125 Plans that function as flexible spending account only plans, or as premium-only plans offering access to benefit options that do not include access to any health care coverage options, will not satisfy these requirements.

Connector regulations require employers to file with the Health Connector Plan Documents covering participants working at Massachusetts locations (information on how an employer can meet this requirement will be available on the Health Connector's website at a later date).

Connector regulations permit Plans to cover employees of two or more employers if the employers are affiliated with or related to one another. In such an instance, the Plan Document should clearly identify all participating employers.

Under the Health Connector regulations, one or more of the following classes of employees may be specifically excluded from eligibility to participate in an employer's Section 125 Plan:

- Employees who are less than 18 years of age
- Temporary Employees
- Part-time Employees working, on average, fewer than 64 hours per month for an Employer
- Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, Section 152A) and who earn, on average, less than \$400 in monthly payroll wages
- Student Employees who are employed as interns or as cooperative education student workers
- Seasonal Employees who are international workers with either a U.S. J-1 student visa, or a U.S. H2B visa and who are also enrolled in travel health insurance

## V. Employee Election and Participation Guidelines

Generally, once an employee has elected to participate in his/her employer's Section 125 Plan, the election cannot be revoked during the Plan Year even if the revocation relates only to the remaining portion of the plan year. However, a Plan may permit a participating employee to revoke an existing election and make a new election for the remaining portion of the plan year if a "change in status" occurs and the election change is consistent with the change in status. "Change in status" events can include:

- A change in the employee's legal marital status
- A change in the employee's number of dependents
- A covered dependent satisfying or ceasing to satisfy the eligibility requirements for coverage
- A change in the employment status of the employee, spouse or dependent
- A change in the place of residence of the employee, spouse or dependent

Mid-year election changes may be permitted by a Plan, as long as they result from:

- Electing or canceling health coverage for a dependent child related to a Qualified Medical Child Support Order ("QMCSO")
- Becoming covered by, or losing coverage under, Medicare or Medicaid
- Experiencing significant cost or coverage changes
- Elections made by spouse or dependent under another employer's plan, or
- Special enrollment rights under HIPAA

## VI. What is Commonwealth Choice?

### **Affordable Choice, Comprehensive Coverage**

The Health Connector was created to help connect employers and their employees with a choice of good, affordable health care coverage options and the tools to help employees choose the option that is right for them. Health care coverage options from six health plans have earned the Health Connector Seal of Approval. These options, all of which comply with the Mass Health Care Reform requirements, will be available to individuals (directly, whether or not premiums are contributed through an employer's Section 125 Plan) and small businesses for effective dates beginning July 1, 2007 under the name Commonwealth Choice.

Commonwealth Choice health care coverage options are available from Blue Cross Blue Shield of Mass, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. Options vary by price and cost sharing, but all offer comprehensive coverage including inpatient and outpatient medical care, emergency care, mental health care and substance abuse services, rehabilitation services, hospice and vision care. Pharmacy coverage options are also available.

Commonwealth Choice health care coverage options will cost as little as \$175 per month on average in the most expensive eastern region of the state. Identical options in central and western Mass will cost about \$154 per month. The net cost to members who pay their premiums on a pre-tax basis through a section 125 Cafeteria Plan will be even lower – up to 40% lower in some cases.

### **Simplified Administration**

Commonwealth Choice coverage will be available for effective dates on or after July 1. Beginning May 1, members may select and enroll in Commonwealth Choice directly with the Health Connector via telephone, the Health Connector's website or fax. As mentioned earlier, while health care coverage options made available under the employer's Section 125 Plan don't need to include those offered through the Health Connector, there are several advantages to doing so.

Employers may allow their employees to access Commonwealth Choice coverage through their Section 125 Plan on a voluntary basis (i.e. with no employer endorsement or contribution). For employees participating in an employer's Section 125 plan, premiums will be deducted on a pre-tax basis by the employer and remitted monthly to the Health Connector.

Additional information on available Commonwealth Choice plans (including benefits, premiums, the enrollment process and key contacts) will be available shortly on the Health Connector's website at [www.MAhealthconnector.org](http://www.MAhealthconnector.org).

## VII. Frequently Asked Questions

### **What is a Section 125 Plan?**

It is a benefit plan that employers may offer under federal tax law that allows employees to pay for health care coverage (and other qualified benefits) on a pre-tax basis. Participating employees' premium contributions are not subject to state, federal or federal FICA withholding taxes. The resulting tax savings could be as much as 40% of the premium cost. Employers also save on FICA taxes.

### **Am I required to offer one?**

Under the Mass Health Care Reform Law (Mass Law), employers with 11 or more full-time equivalent employees must offer one. Full-time equivalent is determined by:

- Calculating the total payroll hours for all of your employees during the 12 months beginning on April 1, 2006
- Dividing by 2,000

For more information, see the Mass Health Care Reform Section 125 Plan Regulations.

### **What types of employers may establish a Section 125 Plan?**

Section 125 Plans are available to:

- C Corporations
- Partnerships
- S Corporations
- Limited Liability Corporations
- Sole Proprietorships
- Professional Corporations
- Non Profit Organizations

### **What is a Premium-Only Plan?**

Under federal law, a range of benefits may be offered through a Section 125 Plan. A premium-only plan is a very basic plan option that employers may offer. It allows eligible employees to contribute to the cost of health care coverage on a pre-tax basis. A premium-only plan provides no other benefits to employees, and is the minimum Plan allowed under the Mass Law.

### **How do employers establish Section 125 Plans?**

Employers should consult their broker, benefits lawyer, payroll vendor and/or accountant and are encouraged to use the sample documents, forms and tools offered by the Health Connector.

### **When must a Section 125 Plan Document be adopted?**

Employers must adopt the written Plan Document on or before the effective date of the Plan.

### **May employers exclude any classes of employees from their Section 125 Plan and still comply with the Mass Health Care Reform Law?**

Yes. Employers may exclude one or more of the following classes of employees:

- Employees under age 18
- Temporary employees
- Part-time employees who average fewer than 64 hours per month
- Wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, Section 152A) who earn, on average, less than \$400 in monthly payroll wages;
- Students who are employed as interns or as cooperative education student workers
- Seasonal Employees under a U.S. J-1 student visa or a U.S. H2B visa, and who are enrolled in travel health insurance

### **Under a Section 125 Plan, how do employees elect to pay for health care coverage on a pre-tax basis?**

An employee must enter into a salary reduction agreement with their employer, confirming that he/she wishes to pay for health care coverage on a pre-tax basis.

### **When do employees enroll in the Section 125 Plan?**

Federal regulations say that employee elections must be made prospectively:

- during an annual open enrollment period
- within a specified period of time following date of hire, or
- the date an employee first becomes eligible under the plan

### **Is an employee required to participate in his/her employer's Section 125 Plan?**

No. However, if an employee chooses not to participate any premium contributions they make toward health care coverage will be on an after-tax basis.

**Are employers required to contribute toward the coverage offered through its Section 125 Plan?**

No. Contributions may be made solely by the employee.

**What happens if an eligible employee works for two or more employers?**

Employees may only participate in one Section 125 Plan. Employees working for two or more employers must select one employer's Plan.

**Are employers that currently offer access to health care coverage through a Section 125 Plan required to establish a separate Plan for employees who are not currently eligible?**

These employers are not required to establish a second Plan, but may now need to offer a Plan to new classes of employees. A separate plan for new classes of employees may make administrative or legal sense for some employers. Employers should consult with their tax or legal advisor.

**Must employers adopt their own Section 125 Plan if they participate in the Plan of a parent, subsidiary or affiliated company?**

No. The Mass Law allows Plans to cover employees of two or more employers if those employers are affiliated or related. The Plan Document should clearly identify all participating employers.

**Must employers file Section 125 Plan Documents with the IRS?**

No.

**Which agency is responsible for the Section 125 Plan requirement under Mass Health Care Reform?**

The Commonwealth Health Insurance Connector Authority (the Health Connector). Section 125 Plan rules and regulations established by the Health Connector are separate from, and in addition to, federal Section 125 Plan rules and regulations.

**Must employers file Section 125 Plan Documents with the Commonwealth?**

Yes. The Mass Law requires employers with employees working at Massachusetts locations to file their Plan Document with the Health Connector. Multi-state and/or international employers with Massachusetts locations should file only those Plan Documents covering participants working at Massachusetts locations.

**Do the Mass Law regulations require Section 125 Plans to follow a particular plan year?**

No.

**Under the Mass Law, are employers that pay 100% of the monthly cost for health care coverage for all employees required to offer a Section 125 Plan?**

No.

**How are premiums collected from participating employees who purchase health care coverage through the Health Connector?**

Employers will withhold contributions from employee paychecks and remit contributions monthly to the Health Connector. The Health Connector tracks those employees through a census of participating employees submitted by the employer.

**Which employees should be listed on the census?**

Only those employees who purchase coverage through the Connector should be included.

**What if an employee's earnings can't cover a premium payment?**

The employer is not responsible for any shortfall amount. The employee must make immediate arrangements to pay any shortfall on an after-tax basis in accordance with procedures specified by the employer. For example, some employers may choose to take the shortfall from the employee and submit it to the Health Connector. Others may direct the employee to send a personal check directly to the Health Connector to cover the shortfall.

## Appendix A - Mass Health Care Reform Section 125 Cafeteria Plan Regulations

### 956 CMR: Commonwealth Health Insurance Connector Authority 956 CMR 4.00 Employer Sponsored Health Insurance Access

- 4.01 Authority
- 4.02 Purpose
- 4.03 Scope
- 4.04 Effective Date
- 4.05 Definitions
- 4.06 Employers Subject to Chapter 151F
- 4.07 Adoption and Maintenance of Section 125 Cafeteria Plan
- 4.08 Filing Section 125 Cafeteria Plan Documents
- 4.09 Other Provisions

#### Section 4.01 Authority

956 CMR 4.00 is promulgated in accordance with the authority granted to the Health Connector by M.G.L. c. 176Q, §16.

#### Section 4.02 Purpose

The purpose of 956 CMR 4.00 is to implement the provisions of M.G.L. c. 151F, which requires Employers with 11 or more Employees to (1) establish and maintain a Section 125 Cafeteria Plan in accordance with the rules and regulations promulgated by the Health Connector, and (2) file a copy of the Section 125 Cafeteria Plan with the Health Connector.

#### Section 4.03 Scope

956 CMR 4.00 contains the Health Connector's regulations governing the requirements of M.G.L. c. 151F. These regulations apply to all Employers with a total of 11 or more Employees at all locations within the Commonwealth of Massachusetts, regardless of whether any underlying medical care coverage accessed through a Section 125 Cafeteria Plan is maintained on an insured or self-insured basis, purchased on an individual or group basis, or provided through the Health Connector or through another distribution channel unrelated to the Health Connector.

#### Section 4.04 Effective Date

956 CMR 4.00 is effective on July 1, 2007.

#### Section 4.05 Definitions

As used in 956 CMR 4.00, unless the context otherwise requires, terms have the following meanings:

**Client Company.** A person, association, partnership, corporation or other entity that is a co-Employer of workers provided by an Employee Leasing Company pursuant to a contract.

**Connector.** The Commonwealth Health Insurance Connector established under M.G.L. c. 176Q.

**Employee.** Any individual employed by any Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident.

**Employee Leasing Company.** A sole proprietorship, partnership, corporation or other form of business entity whose business consists largely of leasing employees to one or more Client Companies under contractual arrangements that retain for such Employee Leasing Companies a substantial portion of personnel management functions, such as payroll, direction and control of workers, and the right to hire and fire workers provided by the Employee Leasing Company; provided, however, that the leasing arrangement is long term and not an arrangement to provide the Client Company temporary help services during seasonal or unusual conditions.

**Employer.** An individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association, corporation or other legal entity, employing employees. Other legal entities shall include, without limitation, the commonwealth, its instrumentalities, political subdivisions, an instrumentality of a political subdivision, including municipal hospitals, municipal electric companies, municipal water companies, regional school districts and any other instrumentalities as are financially independent and are created by statute.

Notwithstanding the preceding paragraph to the contrary, the owner of a dwelling house having not more than 3 apartments and who resides therein, or the occupant of a dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or buildings appurtenant thereto shall not because of such employment be deemed to be an employer. Further, the term “employer” shall neither include nonprofit entities, as defined by the Internal Revenue Code, which are exclusively staffed by volunteers, nor include sole proprietors.

**Independent Contractor.** An individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2 because:

(a) such individual has been and will continue to be free from control and direction in connection with the performance of such services, both under his contract for the performance of service and in fact; and

(b) such service is performed either outside the usual course of the business for which the service is performed or is performed outside of all the places of business of the enterprise for which the service is performed; and

(c) Such individual is customarily engaged in an independently established trade, occupation, profession or business of the same nature as that involved in the service performed.

**Seasonal Employee.** An Employee who is a seasonal employee that works for an Employer that is a seasonal employer, as such terms are defined in M.G.L. c. 151A, section 1.

**Section 125 Cafeteria Plan.** A cafeteria plan that meets the requirements of Title 26, Subtitle A, Chapter I, Subchapter B, Part III, Section 125 of the Internal Revenue Code.

**Temporary Employee.** An individual that works for an Employer on either a full or part time basis; whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

#### **Section 4.06 Employers Subject to Chapter 151F**

**(1) General.** An Employer is subject to the M.G.L. c. 151F requirement to adopt and maintain a Section 125 Cafeteria Plan in accordance with the rules of the Health Connector on and after the date, determined in accordance with 956 CMR 4.06(3), the Employer becomes a 151F Employer as determined in accordance with 956 CMR 4.06(2).

**(2) 151F Employer.** An Employer with 11 or more Employees during the applicable determination period, as determined in accordance with 956 CMR 4.06(3) shall become a Chapter 151F Employer as of the date set forth in 956 CMR 4.06(3).

**(a) Number of Employees.** An Employer has 11 or more Employees if the sum of total payroll hours for all Employees during the applicable determination period divided by 2,000 is greater than or equal to 11. In calculating total payroll hours:

1. For each Employee with more than 2000 payroll hours for the Employer, the Employer shall include 2000 payroll hours.

2. Payroll hours includes all hours for which an Employer paid wages as defined in M.G.L. c. 151A, section 1(s) to an Employee including, by way of example and not by way of limitation, regular, vacation, sick, paid Federal Medical Leave of Absence, short term disability, long term disability, overtime and holiday payroll hours.

3. An Employer who is determined to be a successor under M.G.L. c. 151A shall include the payroll hours of the predecessor's Employees during the applicable determination period.

**(b) Employees.** For purposes of this 956 CMR 4.06, Employees include, by way of example and not by way of limitation, full-time Employees, part-time Employees, Temporary Employees, and Seasonal Employees, regardless of whether his/her Employer is signatory to or obligated under a negotiated, bona fide collective bargaining agreement between such Employer and bona fide Employee representatives that governs the employment conditions

of the Employee. Employees shall also include individuals who are considered self-employed for benefit plan purposes under Internal Revenue Code Section 401(c), but shall not include Independent Contractors.

- (c) Multi-State Employer.** A multi-state Employer with Massachusetts locations shall include all Employees employed at all Massachusetts locations in calculating total payroll hours.
- (d) Certain Employee Leasing Arrangements.** If and to the extent there is a co-employment arrangement between a Client Company and an Employee Leasing Company, the Client Company is the Employer for purposes of M.G.L. c. 151F with respect to those Employees covered under the co-employment arrangement. In the event the Client Company is determined to be a 151F Employer in accordance with 956 CMR 4.06(2), nothing in this 956 CMR 4.00 prohibits the Client Company from contractually allocating to the Employee Leasing Company the responsibility to adopt and maintain a Section 125 Cafeteria Plan for the benefit of the co-employed Employees, in accordance with 956 CMR 4.07, and to comply with the filing requirements in 956 CMR 4.08. However, if and to the extent that the Employee Leasing Company fails to comply with any such responsibilities contractually allocated to it, then the Client Company continues to have responsibility for compliance with this 956 CMR 4.00.
- (e) Employers Providing Noncontributory Medical Coverage.** Notwithstanding anything in this 956 CMR 4.06 to the contrary, an Employer will not be considered a 151F Employer for each month the Employer provides medical coverage to all of its Employees and the Employer pays the full monthly cost of that medical coverage for all of its Employees. This 956 CMR 4.06(2)(e) shall cease to apply on the date the Employer ceases to provide medical coverage to all of its Employees or ceases to pay the full monthly cost of that medical coverage for all of its Employees (the “cessation date”). The Employer shall then determine its status as a 151F Employer in accordance with this 956 CMR 4.06 beginning with the July 1 determination date coincident with or next following the cessation date.

### **(3) Applicable Determination Period**

- (a) Initial Determination Period.** The initial determination period shall be the 12 consecutive month period beginning April 1, 2006 and ending March 31, 2007. An Employer with 11 or more Employees during the initial determination period, as determined in accordance with 956 CMR 4.06(2), shall become a 151F Employer effective July 1, 2007.
- (b) Subsequent Determination Periods.** For those Employers who do not have 11 or more Employees during the initial determination period (or a subsequent determination period, as applicable), as determined in accordance with 956 CMR 4.06(2), July 1, 2008 and each July 1 thereafter will be considered a new determination date for any Employer with less than 11 Employees during the preceding determination period. The applicable subsequent determination period for each July 1 determination date shall be the 12

consecutive month period ending on the June 30 immediately preceding the July 1 determination date. An Employer with 11 or more Employees during a subsequent determination period, as determined in accordance with 956 CMR 4.06(2), shall become a 151F Employer effective on the first day of October following the corresponding July 1 determination date.

#### **Section 4.07 Adoption and Maintenance of Section 125 Cafeteria Plan**

**(1) General.** Pursuant to M.G.L. c. 151F, a 151F Employer is required to adopt and maintain a Section 125 Cafeteria Plan in accordance with regulations and rules promulgated by the Health Connector. A Section 125 Cafeteria Plan must meet the requirements of 956 CMR 4.07(2) and (3) and must be adopted and maintained by the 151F Employer as described in 956 CMR 4.07(4) and (5) respectively. A 151F Employer shall not be in compliance with M.G.L. c. 151F if and to the extent its Section 125 Cafeteria Plan fails to satisfy this 956 CMR 4.07.

**(2) Section 125 Cafeteria Plan Requirements.** A Section 125 Cafeteria Plan must satisfy applicable Internal Revenue Code Section 125 requirements, any applicable U.S. Treasury Department rulings, regulations and guidance, as determined by the Internal Revenue Service, and shall include:

**(a) Written Plan Document.** A Section 125 Cafeteria Plan must consist of a written plan document containing at least the following six elements.

1. A specific description of each of the benefits available under the plan, including the periods during which the benefits are provided. The benefit description need not be self-contained. Benefits described in other separate written plans may be incorporated by reference into the plan document.
2. The plan's eligibility rules regarding participation.
3. The procedures governing participant elections under the plan, including the period during which elections may be made, the extent to which elections are irrevocable, and the periods with respect to which the elections are effective.
4. The manner in which Employer contributions may be made to the plan, such as by salary reduction agreement between the participant and Employer or by non-elective Employer contributions to the plan.
5. The maximum amount of elective Employer contributions available to any participant under the plan either by stating the maximum dollar amount or maximum percentage of compensation that a participant may contribute, or by stating the method for determining the maximum amount or percentage.
6. The plan year on which the cafeteria plan operates.

**(3) Connector Requirements.** In addition, a Section 125 Cafeteria Plan must comply with the following minimum Connector requirements in order to comply with M.G.L. c. 151F:

**(a) Premium Only Plan.** A Section 125 Cafeteria Plan must, at a minimum, be a premium only plan offering access to one or more medical care coverage options in lieu of regular cash compensation.

1. Section 125 Cafeteria Plans that function as flexible spending account only plans, or as premium only plans offering access to benefit options that do not include access to any medical care coverage options will not satisfy this 956 CMR 4.07(3).

2. Flexible spending accounts are not required to be offered as a coverage option.

**(b) Eligibility for Participation.** In connection with a Section 125 Cafeteria Plan offered by a 151F Employer:

1. Employee eligibility requirements for participation in a Section 125 Cafeteria Plan of a 151F Employer (and the extent of such participation) shall be established by the applicable 151F Employer and shall be clearly set forth in its written Section 125 Cafeteria Plan document.

2. A 151F Employer may include an eligibility waiting period in its Section 125 Cafeteria Plan that corresponds with (and is no longer than) any waiting period for enrollment in medical care coverage options available under the Section 125 Cafeteria Plan. However, a Section 125 Cafeteria Plan eligibility waiting period will be considered not in compliance with M.G.L. c. 151F if the waiting period exceeds 2 months (e.g., March 1 to May 1; or March 20 to May 20 is considered two months); even if the waiting period for enrollment in medical care coverage options available under the Section 125 Cafeteria Plan is longer than 2 months. Notwithstanding the foregoing to the contrary, for those Employers that have 151F status as of July 1, 2007, the eligibility waiting period in its Section 125 Cafeteria Plan, if any, for those who are employed on July 1, 2007 may be extended no later than September 1, 2007.

3. An eligible Employee must be offered participation in the Section 125 Cafeteria Plan during any applicable election periods provided for in the written Section 125 Cafeteria Plan document, without regard to whether the eligible Employee was previously eligible or had previously waived participation in the Section 125 Cafeteria Plan during any prior election period.

4. Notwithstanding anything in this 956 CMR 4.00 to the contrary, a 151F Employer may specifically exclude from eligibility to participate in its Section 125 Cafeteria Plan the following classes of Employees without being considered not in compliance with M.G.L. c. 151F with respect to such Employees:

a. Employees who are less than 18 years of age

- b. Temporary Employees
- c. Part-time Employees working, on average, fewer than 64 hours per month for an Employer
- d. Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) and who earn, on average, less than \$400 in monthly payroll wages
- e. Student Employees who are employed as interns or as cooperative education student workers
- f. Seasonal Employees who are international workers with either a U.S. J-1 student visa, or a U.S. H2B visa and who are also enrolled in travel health insurance.

**(c) No Employer Contributions Required.** All contributions made in connection with medical care coverage options offered under a Section 125 Cafeteria Plan may be made solely by Employee salary reduction. Non-elective Employer contributions to the Section 125 Cafeteria Plan are not required.

**(d) Plan Document Configuration.** The Section 125 Cafeteria Plan document may be a separate, stand-alone document or combined/consolidated with other employer-provided plans. A 151F Employer may utilize more than one Section 125 Cafeteria Plan document to provide its Employees with access to medical care coverage options, including a plan established solely for Employees not otherwise eligible for the 151F Employer's subsidized medical care coverage options.

**(e) Affiliated/Participating Employers.** Nothing in this regulation is intended to restrict Section 125 Cafeteria Plan documents from covering Employees of two or more 151F Employers to the extent the Employers are affiliated/related to one another. The plan documentation should clearly identify all participating employers.

**(4) Plan Adoption.** Each 151F Employer shall take such actions as it deems necessary or appropriate to adopt its Section 125 Cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law, regardless of whether the Section 125 Cafeteria Plan is intended to be a newly established plan, a plan amendment to an existing plan or an amended and restated plan.

**(a) Plan Effective Date.** The written plan documentation must clearly state the effective date of the Section 125 Cafeteria Plan (or, if applicable, the effective date of any subsequent plan amendment or restatement intended to conform the Section 125 Cafeteria Plan to M.G.L. c. 151F), which shall be no later than the date the Employer became a 151F Employer, as determined in accordance with 956 CMR 4.06.

**(b) Affiliated/Participating Employers.** Each 151F Employer who is a participating Employer in an affiliated/related Employer's Code Section 125 Cafeteria Plan shall take such

actions as it deems necessary or appropriate to adopt such Section 125 Cafeteria Plan(s) in accordance with its own internal governance procedures and with applicable law.

**(5) Plan Maintenance.** A Section 151F Employer shall be deemed to maintain a Section 125 Cafeteria Plan as required by M.G.L. c. 151F if the plan meets the Cafeteria Plan requirements in 956 CMR 4.07 (2), the Health Connector requirements in 956 CMR 4.07(3), has been adopted in accordance with 956 CMR 4.07 (4), and has not been subsequently terminated by the 151F Employer.

#### **Section 4.08 Filing Section 125 Cafeteria Plan Documents**

**(1) General.** Pursuant to M.G.L. c. 151F, a 151F Employer is required to file a copy of its Section 125 Cafeteria Plan(s) with the Health Connector.

#### **(2) Filing Requirements.**

- (a) Each 151F Employer shall submit a copy of its Section 125 Cafeteria Plan(s) to the Health Connector, or its designee, on or before the effective date of its 151F Employer status. Any Section 125 Cafeteria Plan maintained by a 151F Employer that is not available to any Employees employed at a Massachusetts location is not subject to the filing requirement and need not be submitted to the Health Connector.
- (b) Each submission shall be in the form and manner specified by the Health Connector and shall include such other documentation related to the 151F Employer's Section 125 Cafeteria Plan as the Health Connector may from time to time require.
- (c) An Employer must designate a responsible individual authorized to verify and certify the accuracy of the documentation submitted.
- (d) The Health Connector may change the filing requirements, including specified forms and filing deadlines, by administrative bulletin.

#### **Section 4.09 Other Provisions**

**(1) Compliance Enforcement.** Compliance with M.G.L. c. 151F and this 956 CMR 4.00 will be enforced by the attorney general. Noncompliance may subject a 151F Employer to the Employer Surcharge for State-Funded Health Costs described in M.G.L. c. 118G and any regulations promulgated there under, as amended from time to time.

**(2) Consistency with Section 125.** The Health Connector intends that these regulations neither be inconsistent with Internal Revenue Code Section 125, nor require any Employer to take any action that would violate Internal Revenue Code Section 125.

**(3) No ERISA Plan.** In general, a Section 125 Cafeteria Plan is not an ERISA welfare benefit plan and nothing in these regulations is intended to require any Employer to establish an ERISA welfare benefit plan.

**(4) Administrative Information Bulletins.** The Health Connector may issue administrative information bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to implement 956 CMR 4.00.

**(5) Severability.** The provisions of 956 CMR 4.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 4.00 or the application of such provisions.

#### REGULATORY AUTHORITY

956 CMR 4.00; M.G.L. c. 176Q.

## Appendix B-I - Implementation Checklist

### ABC Company Cafeteria Plan

Check When  
Completed

**1. Adoption Agreement – Section 125 Cafeteria Plan  
(including Schedules A, B, C & D)**

Complete in its entirety, sign and date no later than the effective date of the Plan.

**2. Cafeteria Plan Document for "Premium-Only" Section 125 Plan**

A copy of the Cafeteria Plan Document template along with the Adoption Agreement constitutes your Cafeteria Plan. Please retain these documents as part of your permanent records.

**3. Cafeteria Plan – Plan Description**

Complete and distribute to all eligible employees no later than the effective date of the Plan.

**4. Employee Elections**

Each eligible employee will be required to complete a Participation Election Form and Compensation Reduction Agreement authorizing the Employer to withhold the employee cost of the health care coverage pre-tax.

*Note: Eligible employees must be given the option to elect out of the Section 125 Cafeteria Plan by completing a Participation Waiver Form.*

**5. Retain** – Signed copy of form (Participation Waiver/Election Form and Compensation Reduction Agreement).

**6. Payroll** – Notify payroll department/service and advise that contributions for health care coverage are to be deducted pre-tax beginning on the plan's effective date.

**7. The Health Connector** – Establish an account and provide to the Health Connector a census of participating employees for whom premiums for health care coverage purchased through the Health Connector are to be remitted by the employer (for more information, contact the Connector).

**8. File** – Cafeteria Plan document from item 2 above with the Health Connector in the time and manner required by the Health Connector in its regulation and any subsequently issued guidance.

## Appendix B-2 - New Hire Checklist

### ABC Company Cafeteria Plan

Check When  
Completed

**1. Cafeteria Plan** – Plan Description – Distribute a Plan Description to the new employee prior to employee’s eligibility to elect the Plan.

**2. Election Forms** - Each eligible employee will be required to complete a Participation Election and Compensation Reduction Form authorizing the Employer to withhold the employee cost of the health care coverage on a pre-tax basis.

*Note: Eligible employees must be given the option to elect out of the Section 125 Cafeteria Plan by completing a Participation Waiver Form.*

**3. File** - File the signed forms and maintain as part of your permanent records.

**5. Payroll Service** - Contact your payroll service and advise that the new employee will be participating (pre-tax) in the Section 125 Cafeteria Plan.

**4. The Health Connector** – Notify the Health Connector that the new employee should be added to your account (for more information, contact the Health Connector).

## Appendix C-1 - Employer Adoption Agreement

For review by Employer sponsor and its legal counsel

THIS AGREEMENT IS INTENDED FOR USE BY EMPLOYERS ALLOWING EMPLOYEES TO ACCESS COMMONWEALTH CHOICE COVERAGE THROUGH A SECTION 125 CAFETERIA PLAN ON A VOLUNTARY BASIS. IT IS NOT INTENDED FOR USE BY SMALL GROUP EMPLOYER SPONSORS DESIGNATING A BENCHMARK PLAN AND MAKING AN EMPLOYER CONTRIBUTION.

This Adoption Agreement must be completed in conjunction with the accompanying “Premium Only” Section 125 Cafeteria Plan document. These documents should be reviewed by the Employer Sponsor and its legal counsel prior to execution.

### I. Basic Plan Information.

A. The name of the adopting Employer Sponsor is:

\_\_\_\_\_

B. The name of the Plan shall be the Section 125 Cafeteria Plan for [name of adopting Employer Sponsor listed in Section I.A above] (hereinafter referred to as the “Plan”).

C. The Effective Date (the initial effective date following adoption) of the Plan is: \_\_\_\_\_ . In the event that the accompanying Plan document is an amended and restated version of the Plan previously adopted by the Employer Sponsor, the amended and restated Plan document shall be effective as of the date set forth on the cover page of the Plan document.

D. The effective date of the Employer Sponsor’s status as a 151F Employer in accordance with 956 CMR 4.00 is: (check one)

July 1, 2007; or

October 1, 20\_\_.

E. The Plan Year of the Plan is: (check one)

the period beginning on the Effective Date and ending on the next following June 30 and each 12-consecutive month period beginning July 1 thereafter;

the period beginning on the Effective Date and ending on the next following December 31 and each 12-consecutive month period beginning January 1 thereafter;

the period beginning on the Effective Date and ending on the next following March 31, and each 12-consecutive month period beginning April 1 thereafter; or

Other:

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F. The Employer Sponsor's Federal "Employer Identification Number" is:

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G. The Employer Sponsor's State "Employer Identification Number" is:

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**II. Participating Employers. The definition of "Employer" under the Plan includes the Employer Sponsor and any Participating Employers.**

**DEFAULT ELECTION:** (check if elected)

The default election under the Plan is that no organization or other entity that is affiliated with or related to the Employer Sponsor shall participate in this Plan as a Participating Employer.

In lieu of the default election, the Employer Sponsor may elect to permit some or all organizations or entities affiliated with or related to the Employer Sponsor to participate as Participating Employers under this Plan as follows:

**OPTIONAL ELECTION:** (check if elected in lieu of default option and please complete Schedule D of this Adoption Agreement):

The Employer Sponsor elects to include under this Plan the Participating Employers listed on Schedule D, which shall each be considered an Employer under the Plan. The Employer Sponsor assumes full responsibility for such designation.

**III. Participant Eligibility.**

**DEFAULT ELECTION:** (check if elected)

The default election under the Plan is that all Employees shall become Eligible Employees upon meeting the eligibility requirements set forth on Schedule A. Please complete Schedule A of this Adoption Agreement.

In lieu of the default election, the Employer Sponsor may elect to exclude certain classes of Employees as follows:

**OPTIONAL ELECTION:** (check if elected in lieu of default option and please complete Schedule A of this Adoption Agreement):

Employees shall become Eligible Employees upon meeting the eligibility requirements set forth on Schedule A (please complete Schedule A of this Adoption Agreement); provided, however, that the following classes of Employees are excluded from the definition of Eligible Employee (if elected, check all that apply):

- Employees who are eligible for any other Section 125 Cafeteria Plan of the Employer.
- Employees who are less than 18 years of age.
- Temporary Employees, as defined in the Plan.
- Employees regularly scheduled to perform less than sixty-four (64) hours per month for an Employer.
- Employees who are considered wait staff, service employees or service bartenders (as defined in M.G.L. c. 149, section 152A) and who earn, on average, less than \$400 in monthly payroll wages.
- Student Employees who are employed as interns or as cooperative education student workers.
- Seasonal Employees, as defined in the Plan, who are international workers with either a U.S. J-1 student visa, or a U.S. H2B visa and who are also enrolled in travel health insurance.
- Other excluded classes (if elected, please complete Schedule A of this Adoption Agreement).

#### **IV. Employer Contributions.**

**DEFAULT ELECTION:** (check if elected)

The default election under the Plan is that the Employer will not make any contributions toward the monthly cost of coverage elected by the Participant under the Plan. Therefore, under this default election, the Participant is responsible for 100% of the monthly cost of coverage elected by the Participant under the Plan.

In lieu of the default election, the Employer Sponsor may elect to make periodic contributions toward the monthly cost of coverage as follows:

**OPTIONAL ELECTION:** (check if elected in lieu of default option and please complete Schedule B of this Adoption Agreement):

The Employer Sponsor elects to make periodic contributions toward the monthly cost of coverage elected by Participants under the Plan.

Please complete Schedule B of this Adoption Agreement to establish the formula for Employer Contributions (required if this option is elected).

## V. Medical Care Coverage Options.

### **DEFAULT ELECTION:** (check if elected)

The default medical care coverage options available to Participants under the Plan are any and all policies of medical insurance that have been granted the seal of approval by the Commonwealth Health Insurance Connector Authority. Any medical care coverage option that subsequently loses the Health Connector's seal of approval will continue to be a medical care coverage option under the Plan, but only to the extent that Participants enrolled in such medical care coverage option on the date the seal of approval is lost remain enrolled in that medical care coverage option without interruption.

Such medical care coverage options are available to Participants on a voluntary basis, without endorsement by the Employer and are not intended to be part of the Employer's benefit program.

In lieu of the default election, the Employer Sponsor may elect the following:

### **OPTIONAL ELECTION:** (check if elected in lieu of default option and please complete Schedule C of this Adoption Agreement):

The following will be considered medical care coverage options available to Participants under the Plan:

Any and all policies of medical insurance that have been granted the seal of approval by the Commonwealth Health Insurance Connector Authority. Any medical care coverage option that subsequently loses the Health Connector's seal of approval will continue to be a medical care coverage option under the Plan, but only to the extent that Participants enrolled in such medical care coverage option on the date the seal of approval is lost remain enrolled in that medical care coverage option without interruption.

Any other medical insurance identified on Schedule C (please complete Schedule C of this Adoption Agreement).

Such medical care coverage options are available to Participants on a voluntary basis, without endorsement by the Employer and are not intended to be part of the Employer's benefit program.

## VI. Employer Sponsor's Execution of Adoption Agreement

Having made the elections described in this Adoption Agreement, the Employer Sponsor hereby adopts the Plan (consisting of this Adoption Agreement, including Schedules, and the attached Section 125 Cafeteria Plan document), which Plan is hereby executed in its name and on its behalf by a duly authorized representative of the Employer Sponsor, or his or her authorized delegate.

For the employer Sponsor

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

WITNESS SIGNATURE

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Schedule A

### **ELIGIBILITY REQUIREMENTS UNDER THE PLAN; OTHER CLASSES OF EMPLOYEES EXCLUDED FROM THE DEFINITION OF ELIGIBLE EMPLOYEE UNDER THE PLAN**

Describe eligibility requirements under the Plan below:

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(General Rule: The eligibility requirements above may include an eligibility waiting period that corresponds with (but is no longer than) any waiting period for enrollment in medical care coverage options available under this Plan, but in no event may the eligibility waiting period under this Plan exceed 2 months (e.g., March 1 to May 1; or March 20 to May 20 is considered two months); even if any waiting period for enrollment in medical care coverage options available under this Plan is longer than 2 months.

Special rule for Employers complying with M.G.L. c. 151F as of July 1, 2007: the eligibility waiting period, if any, under this Plan for those who are employed on July 1, 2007 may be extended to no later than September 1, 2007.)

Describe other classes of excluded employees below:

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The Employer Sponsor represents that it has consulted with its own legal counsel, and assumes full responsibility for its exclusion elections.

## Schedule B

### FORMULA FOR EMPLOYER CONTRIBUTIONS UNDER THE PLAN

Describe the Employer contribution amount per Participant. This amount may be expressed as a percentage of monthly cost or as a flat monthly dollar amount.

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If the formula for Employer contributions varies by class of Employees, the Employer Sponsor assumes full responsibility for its Employer contribution design.

In no event shall the existence of any Employer contributions for monthly premium costs, as indicated above, be construed to require the Employer to pay or otherwise be liable for any deductible, coinsurance, co-payment or other cost-sharing amounts related to the applicable medical care coverage option elected by the Participant.

## Schedule C

### **ADDITIONAL MEDICAL CARE COVERAGE OPTIONS UNDER THE PLAN**

Describe any additional medical care coverage options available to Participants under the Plan. Include the effective date the coverage is first available as a medical care coverage option under the Plan.

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## Schedule D

### **PARTICIPATING EMPLOYERS OF THE EMPLOYER SPONSOR**

The following organizations and entities that shall be Participating Employers under the Plan:

Name of Participating Employer	Federal Employer Identification Number

## Appendix C-2 - Plan Document for Premium-only Plan

### **Plan Document for Premium-only Plan**

[Amended and Restated], Effective July 1, 2007  
For review by employer sponsor and its legal counsel

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Article 1. Introduction.

- 1.1. Establishment; Purpose of Plan. The Employer Sponsor [adopts] [amends, restates and continues] the Plan consisting of this Plan document, the Adoption Agreement, the attached Schedules, and amendments thereto. The name of the Plan shall be the name stated in Section I.A. of the Adoption Agreement. The purpose of this Plan is to provide Participants with a choice between regular cash compensation and Optional Benefit Coverages.
- 1.2. Cafeteria plan status. This Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and is to be interpreted in a manner consistent with the requirements of Section 125. To the extent required, this Plan is also intended to be maintained as required by, and in accordance with, M.G.L. c. 151F, 956 CMR 4.00 and such other rules and regulations of the Commonwealth Health Insurance Connector Authority, as amended from time to time.

Article 2. Definitions.

Wherever used in this Plan, the singular includes the plural and the following terms have the following meanings, unless a different meaning is clearly required by the context:

- 2.1. "Administrator" means the Employer Sponsor or such other person or committee as may be appointed from time to time by the Employer Sponsor to supervise the administration of the Plan.
- 2.2. "Code" means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any regulations there under and any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.
- 2.3. "Coverage Period" means the Plan Year.
- 2.4. "Effective Date" means the date set forth in Section I.C. of the Adoption Agreement.
- 2.5. "Eligible Employee" means an Employee who meets the eligibility requirements described in Section III of the Adoption Agreement. An individual who does not meet the eligibility requirements in the Adoption Agreement shall not be eligible to participate in the Plan under any circumstances.
- 2.6. "Employee" means any individual who is employed by the Employer at a Massachusetts location, whether or not the individual is a Massachusetts resident. Employee includes, by way of example and not by way of limitation, full-time Employees, part-time Employees, Temporary Employees, and Seasonal Employees. Employee shall not include an Independent Contractor or an individual who is self-employed in accordance with Code section 401(c).

- 2.7. "Employer" means the Employer Sponsor and each Participating Employer.
- 2.8. "Employer Sponsor" means the entity identified in Section I.A of the Adoption Agreement and any successor to all or a major portion of its assets or business, by merger or otherwise, that assumes the obligations of the Employer Sponsor under the Plan.
- 2.9. "Independent Contractor" means an individual that provides services not deemed to be employment under M.G.L. c. 151A, § 2.
- 2.10. "Key Employee" means any person who is a key employee, as defined in section 416(i)(1) of the Code, with respect to the Employer.
- 2.11. "Optional Benefit Coverages" means the medical care coverage option(s) ("MCCO") available to a Participant as set forth in Section V of the Adoption Agreement.
- 2.12. "Participant" means any individual who participates in the Plan in accordance with Article 3.
- 2.13. "Participating Employer" means any subsidiary or affiliated organization or entity and any successor(s) of any of them which, with the approval of the Employer Sponsor, and subject to such conditions as the Employer Sponsor may impose, adopts the Plan.
- 2.14. "Plan" means the cafeteria plan set forth in this Plan document and the Adoption Agreement, the name of which is designated in the Adoption Agreement, together with any and all Schedules and amendments thereto. The terms of this Plan document shall be interpreted in accordance with the elections made by the Employer Sponsor in the Adoption Agreement.
- 2.15. "Plan Year" means the period set forth in Section I.E of the Adoption Agreement.
- 2.16. "Seasonal Employee" means an Employee who is a seasonal employee that works for an Employer that is a seasonal employer, as such terms are defined in M.G.L. c. 151A, section I.
- 2.17. "Temporary Employee" means an individual that works for an Employer on either a full or part time basis; whose employment is explicitly temporary in nature and does not exceed 12 consecutive weeks during the period from October 1 through September 30.

### Article 3. Participation.

- 3.1. Commencement of participation. Each Eligible Employee will become a Participant in this Plan on the date he or she becomes an Eligible Employee, subject to his or her completion of any applicable waiting period set forth on the attached the Adoption Agreement. Each Participant may elect Optional Benefit Coverages in accordance with, and subject to, the procedures set forth in Article 4 and such other procedures as may be established by the Administrator from time to time.

- 3.2. Cessation of participation. A Participant will cease to be a Participant as of the earlier of (a) the date on which the Plan terminates or (b) the date on which he or she ceases to be an Eligible Employee.
- 3.3. Reinstatement of former Participant. A former Participant who meets the requirements for an Eligible Employee will become a Participant again if and when he or she becomes an Eligible Employee, subject to the completion of any applicable waiting period.

Article 4. Optional Benefit Coverages.

- 4.1. Coverage options. Each Participant may choose under this Plan to receive his or her full compensation in cash or to have all or a portion of such compensation applied by the Employer toward the cost of the Optional Benefit Coverages elected by the Participant. Notwithstanding anything herein to the contrary, Optional Benefit Coverages shall be limited to those medical care coverage options (MCCO ) identified in Section V of the Adoption Agreement to the extent they are available to the Participant.
- 4.2. Description of Optional Benefit Coverages. While the election of Optional Benefit Coverages may be made under this Plan, the coverages and benefits elected by Participants will be provided not by this Plan but by the applicable MCCO identified in the Adoption Agreement. The types and amounts of benefits available under each MCCO, the requirements for participating in such MCCO, and the other terms and conditions of coverage and benefits under such MCCO are as set forth from time to time in the insurance policy forms that constitute (or are incorporated by reference in) the applicable MCCO. The benefit descriptions in such MCCO and in the evidence of coverage corresponding to such MCCO, as in effect from time to time, are hereby incorporated by reference into this Plan.
- 4.3. Election of Optional Benefit Coverages in Lieu of Cash. A Participant may elect under this Plan, in accordance with the procedures described in Sections 4.4, 4.5 and 4.6, to receive one or more Optional Benefit Coverages to the extent available to the Participant under the Adoption Agreement. If a Participant elects an Optional Benefit Coverage for a Coverage Period, and if the Participant is required to pay all or a share of the cost of such coverage in accordance with Section IV of the Adoption Agreement, such share shall be paid by a reduction in the Participant's regular compensation for the Coverage Period. The balance of the cost of each such coverage, if any, shall be paid by the Employer under this Plan with nonelective Employer contributions. In the event that the Participant's regular compensation is insufficient in amount to pay the Participant's share of the monthly cost of such Optional Benefit Coverage by compensation reduction, the Employer has no responsibility under this Plan to cover, pay or advance on behalf of the Participant any such shortfall and the Participant shall make immediate arrangements to pay any such shortfall on an after-tax basis in accordance with the procedures specified by the Administrator.
- 4.4. Election procedure. Prior to the commencement of each Coverage Period, the Administrator shall provide (or make available) a means of election for each Participant and for each other

individual who is expected to become a Participant at the beginning of the applicable Coverage Period. The election shall be effective as of the first day of the Coverage Period. Each Participant who desires to elect an Optional Benefit Coverage available for the Coverage Period shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be made on or before such date as the Administrator shall specify.

4.5. New Participants. Before, or as soon as practicable after, an individual becomes a Participant under Section 3.1 or 3.3, the Administrator shall provide the means of election described in Section 4.4 to the individual. If the individual desires one or more Optional Benefit Coverages for the balance of the Coverage Period, the individual shall so specify in his or her election. The Participant shall agree to a reduction in his or her compensation equal to the cost of the Optional Benefit Coverages elected by the Participant. Each election must be made on or before such date as the Administrator shall specify.

4.6. Failure to make election.

- (a) A new Participant's failure to make an election under Section 4.4 or 4.5 on or before the due date specified by the Administrator for the Coverage Period in which he or she becomes a Participant shall constitute an election by the Participant to receive his or her full compensation in cash.
- (b) An existing Participant's failure to make an election relating to an Optional Benefit Coverage on or before the due date specified by the Administrator for any subsequent Coverage Period shall constitute (1) a re-election of the same coverage, if any, as was in effect just prior to the end of the preceding Coverage Period (to the extent such Optional Benefit Coverage remains available under the Plan), and (2) an agreement to a reduction in the Participant's compensation for the subsequent Coverage Period equal to the cost of such coverage.

4.7. Revocation or change of election by the Participant during the Coverage Period.

- (a) Any election made under the Plan (including an election made through inaction under Section 4.6) shall be irrevocable by the Participant during the Coverage Period except as otherwise provided in (b) through (k) below.
- (b) With respect to an Optional Benefit Coverage, a Participant may revoke an election for the balance of the Coverage Period and, if desired, file a new election in writing if, under the facts and circumstances, (1) a change in status occurs, and (2) the requested revocation and new election satisfy the consistency requirements in Section 4.8 below. For this purpose, a change in status includes the following events:
  - (1) Legal marital status. An event that changes a Participant's legal marital status, death of spouse, divorce, or legal separation or annulment.

- (2) Number of dependents. An event that changes a Participant's number of dependents (as defined in Code Section 152), including birth, death, adoption or placement for adoption.
  - (3) Employment Status. An event that changes the employment status of the Participant, the Participant's spouse or dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of the Employer.
  - (4) Requirements For Unmarried Dependents. An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.
  - (5) Residence. A change in the place of residence of the Participant or his or her spouse or dependent.
  - (6) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Coverage Period under regulations and rulings of the Internal Revenue Service.
- (c) In the case of coverage under a medical plan identified in the Adoption Agreement, a Participant may revoke an election for the balance of the Coverage Period and file a new election that corresponds with the special enrollment rights provided in Code Section 9801(f) pertaining to HIPAA special enrollment rights, whether or not the change in election is permitted under Section 4.7(b) above.
  - (d) In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires health coverage for a Participant's child or for a foster child who is a dependent of the Participant, a Participant may change his or her election (1) in order to provide coverage for the child under a health coverage identified in the Adoption Agreement if the order so requires, or (2) in order to cancel a health coverage identified in the Adoption Agreement for the Participant's child if such order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.
  - (e) In the case of a medical Optional Benefit Coverage, a Participant may revoke an election in writing for the balance of the Coverage Period and file a new election in writing in order to cancel or reduce such medical Optional Benefit Coverage for the Participant and/or for one or more covered dependents of the Participant to the extent that such individual becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other

than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election in writing for the balance of the Coverage Period to commence or increase a medical Optional Benefit Coverage.

- (f) In the case of a medical Optional Benefit Coverage, if the Participants' share of the cost of such coverage significantly increases or significantly decreases during the Coverage Period, the Participants may make a corresponding change in election under the Plan for the balance of the Coverage Period, as follows:
  - (1) for a significant cost increase, Participants electing such coverage for the Coverage Period may revoke their election and either elect a similar Optional Benefit Coverage for the balance of the Coverage Period, or drop such coverage if there is no similar Optional Benefit Coverage; or
  - (2) for a significant cost decrease, Participants may elect to commence participation in the Optional Benefit Coverage with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Coverage Period.
- (g) In the case of a medical Optional Benefit Coverage, if the Participant or his or her spouse or dependent experience a significant curtailment in coverage during the Coverage Period, the Participant may make a corresponding change in election under the Plan for the balance of the Coverage Period as follows:
  - (1) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Coverage Period may revoke his or her election and elect a similar medical Optional Benefit Coverage for the balance of the Coverage Period; or
  - (2) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Coverage Period may revoke his or her election and either elect a similar Optional Benefit Coverage for the balance of the Coverage Period, or drop such coverage if there is no similar Optional Benefit Coverage.
- (h) If during the Coverage Period a new Optional Benefit Coverage becomes available, or an existing Optional Benefit Coverage is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Coverage Period.
- (i) In the event that a Participant's spouse or dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the

Coverage Period that is on account of and corresponds with the election change made by the Participant's spouse or dependent, if:

- (1) the election change made by the Participant's spouse or dependent under his or her employer's plan satisfies the regulations and rulings under Code section 125; or
  - (2) the period of coverage under the plan maintained by the employer of the Participant's spouse or dependent does not correspond with the Coverage Period of this Plan.
- (j) In the event that a Participant, his or her spouse or dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect a medical Optional Benefit Coverage for the balance of the Coverage Period for the Participant, his or her spouse or dependent.
- (k) Any application for a revocation and new election under this Section 4.7 must be made within the time specified by the Administrator following the date of the actual event and shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law.
- 4.8. Consistency Rules. A Participant's requested revocation and new election will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's spouse or dependent. A change in status that affects eligibility under the Employer's plan shall include a change in status that results in the increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the plan.
- 4.9. Changes by Administrator. If the Administrator determines, before or during any Coverage Period, that the Plan may fail to satisfy for such year any nondiscrimination or other requirement imposed by the Code or any limitation on benefits provided to Key Employees, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated participants, to assure compliance with such requirement or limitation. Such action may include, without limitation, a modification of elections by highly compensated Employees (as defined by the Code for purposes of the nondiscrimination requirement in question) or Key Employees without the consent of such Employees.
- 4.10. Adjustment of Compensation Reductions. If the cost of an Optional Benefit Coverage provided to a Participant increases or decreases during a Coverage Period, including any increase or decrease due to a change in the Participant's salary, a corresponding change shall be made in the compensation reductions of the Participant in an amount reflecting such increase or decrease, as determined by the Administrator.
- 4.11. Automatic termination of election. Any election made under this Plan (including an election made through inaction under Section 4.6) shall automatically terminate on the date on which the

Participant ceases to be a Participant in the Plan, although coverage or benefits may continue if and to the extent provided by such coverage. In the event such a former Participant again becomes a Participant within 30 days of ceasing to be a Participant, the elections previously in effect for the Participant shall be automatically reinstated for the balance of the Coverage Period, except as otherwise elected by the Participant in accordance with Section 4.7.

- 4.12. Maximum elective contributions. The maximum amount of elective contributions under the Plan for any Participant shall be the total cost to the Participant for the Coverage Period of the most expensive Optional Benefit Coverages that any Participant could elect.
- 4.13. Cessation of required contributions. Nothing in this Plan shall prevent the cessation of coverage or benefits under any Optional Benefit Coverage, in accordance with the terms of such coverage, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction or otherwise.
- 4.14. Elections Via Other Media. The Administrator may, in its discretion, use any telephonic, electronic or other alternative media form that it deems necessary or appropriate for the election of Optional Benefit Coverages under the Plan.
- 4.15. Coordination with FMLA. Notwithstanding any other provision of this Plan, the Administrator may (a) permit a Participant to revoke (and subsequently reinstate) his or her election of one or more Optional Benefit Coverages under the Plan, and (b) adjust a Participant's compensation reduction as a result of a revocation or reinstatement to the extent the Administrator deems necessary or appropriate to assure the Plan's compliance with the provisions of the Family and Medical Leave Act of 1993 and any regulations pertaining thereto.
- 4.16. Special Rule for Certain Covered Individuals. Notwithstanding anything in this Plan to the contrary, the cost of providing Optional Benefit Coverage to an individual as a dependent of the Participant (where the covered individual is not a dependent of the Participant for purposes of Code section 152, as modified by Code section 105(b) and IRS Notice 2004-79) shall be paid by the Participant with after-tax contributions. Such costs shall either be deducted by the Employer from the after-tax compensation of the Participant or, to the extent the cost of such Optional Benefit Coverage is paid from compensation reduction or any other form of Employer contribution, shall be treated as taxable compensation received by the Participant and contributed by the Participant on an after-tax basis.

#### Article 5. Administration of Plan.

- 5.1. Plan Administrator. The administration of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Administrator will have full discretionary power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose,

the Administrator's discretionary powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

- (a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
- (b) To interpret the Plan;
- (c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;
- (d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and
- (e) To delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such delegation or designation to be in writing.

Any determination by the Administrator, or its authorized delegate, shall be final and conclusive on all persons, in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously. Notwithstanding the foregoing, any claim which arises under any Optional Benefit Coverage shall not be subject to review under this Plan, and the Administrator's authority under this Section 5.1 shall not extend to any matter as to which another administrator or entity is empowered to make determinations under such Optional Benefit Coverage.

5.2. Examination of records. The Administrator will make available to each Participant such of its records under the Plan as pertain to the Participant, for examination at reasonable times during normal business hours; provided, however, the Administrator shall have no obligation to disclose any records or information which the Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

5.3. Reliance on tables, etc. In administering the Plan, the Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrators of the plans identified in the Adoption Agreement, or by accountants, counsel or other experts employed or engaged by the Administrator.

5.4. Nondiscriminatory exercise of authority. Whenever, in the administration of the Plan, any discretionary action by the Administrator is required, the Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated will receive substantially the same treatment.

Article 6. Amendment and Termination of Plan.

6.1. Amendment of Plan. The power to amend the Plan, in whole or in part, shall be vested in the Employer Sponsor, which shall have the sole discretion to make all amendments to the Plan or any of its provisions. Such amendment shall be effected by a written instrument signed by a duly authorized representative of the Employer, or his or her authorized delegate, and delivered to the Administrator.

Subject to the foregoing provisions, the Schedules in the Adoption Agreement may be amended without the need to execute a new Adoption Agreement. Such amendment shall be made by the Employer in a written certification specifying that the Plan is amended by substituting the amended Schedule.

6.2. Termination of Plan. The Employer has established the Plan with the bona fide intention and expectation that it will be continued indefinitely, but the Employer will have no obligation whatsoever to maintain the Plan for any given length of time and may discontinue or terminate the Plan at any time, without liability, by a written instrument signed by a duly authorized representative of the Employer, or his or her authorized delegate, and delivered to the Administrator.

Article 7. Miscellaneous Provisions.

7.1. Information to be furnished. Participants shall provide the Employer and the Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

7.2. Limitation of rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits, will be construed as giving to any Participant or other person any legal or equitable right against the Employer or the Administrator, except as provided herein.

7.3. Employment Not Guaranteed. Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Employee any right to be retained in the employ of the Employer.

7.4. Governing law. Except to the extent federal law applies, this Plan shall be construed, administered and enforced according to the laws of the Commonwealth of Massachusetts.

## Appendix C-3 - Plan Description for Premium-only Plan

### Plan Description for Premium-only Plan

[Amended and Restated/Effective] \_\_\_\_\_

THIS PLAN DESCRIPTION IS INTENDED FOR USE BY EMPLOYERS ALLOWING EMPLOYEES TO ACCESS COMMONWEALTH CHOICE COVERAGE THROUGH A SECTION 125 CAFETERIA PLAN ON A VOLUNTARY BASIS. IT IS NOT INTENDED FOR USE BY SMALL GROUP EMPLOYER SPONSORS DESIGNATING A BENCHMARK PLAN AND MAKING AN EMPLOYER CONTRIBUTION.

This plan description provides an overview of the requirements for participation in the Section 125 Cafeteria Plan and is intended to be a brief summary. The Plan is governed by a formal plan document. If there are any differences between this summary and the official plan document, the plan document will govern.

## Introduction

We are pleased to announce that we have [established/amended and restated] our Section 125 Cafeteria Plan (the “Plan”) under which you may pay your medical care coverage premiums on a pre-tax basis. Under the Massachusetts Health Care Reform Law, you are now eligible for favorable tax treatment of your medical care coverage premiums even though you are not eligible for medical care coverage through your Employer. Your participation in this Plan is completely voluntary.

## Participation In The Plan

Under the Plan, you may choose to receive your entire compensation in cash or use a portion of it to pay for certain medical care coverage premiums (See “Medical Care Coverage” below). When you elect to pay for your medical care coverage premiums, your regular compensation will be reduced on a pre-tax basis by the amount of your premium payment for the coverage you have selected. This means that you will pay less in taxes each year.

*Important note: If you decide to pay for medical care coverage using pre-tax income, the amount withheld from your pay will not be subject to federal income or Social Security (“FICA”) taxes. This could result in a reduction in the Social Security benefits you receive at retirement if you earn less than the “taxable wage base.” The taxable wage base for 2007 is \$97,500 and is adjusted annually. The tax advantages you gain by paying your medical care coverage premiums with pre-tax income may, however, offset any possible reduction in Social Security benefits and you should consult a tax advisor to determine whether in your situation the benefits achieved outweigh any potential reduction of Social Security benefits.*

## Medical Care Coverage

You can use pre-tax dollars to purchase any medical care coverage that has been granted the seal of approval by the Commonwealth Health Insurance Connector Authority (the “Connector”).<sup>1</sup> This coverage is not offered through this Plan or through your Employer, is not endorsed by your Employer and is not part of your Employer’s benefit program. Your eligibility for the medical care coverage is determined by the Health Connector and the applicable insurance carrier.

Additionally, although the Health Connector has granted its seal of approval to these medical care coverage options, coverage is provided by the insurance carrier issuing the applicable medical insurance policy. Neither the Health Connector nor your Employer have any liability for any benefits due, or alleged to be due, under any such medical insurance policies.

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<sup>1</sup> [This section will need to be tailored if additional medical care coverage options are made available.]

## Eligibility

You are eligible to participate in this Plan if (i) you are an employee of [insert name of company], (the “Employer”); (ii) you are not an “excluded employee;” and (iii) you have completed [ ] months of service.<sup>2</sup>

You are an “excluded employee” if you are:

- (i) eligible for another Section 125 Cafeteria Plan offered by your Employer;
- (ii) less than 18 years of age;
- (iii) covered by a collective bargaining agreement unit if health benefits were the subject of good faith bargaining;
- (iv) a temporary employee;
- (v) regularly scheduled to perform fewer than 64 hours per month;
- (vi) wait staff, service employee or service bartender and you earn less than \$400 in monthly payroll wages;
- (vii) a student employee employed as an intern or a cooperative education student worker;
- (vii) a seasonal employee who is an international worker with either a U.S. J-1 student visa, or a U.S. H2B visa and you have travel health insurance; or
- (vii) [other].

## Electing To Participate In The Plan

If you are eligible to participate in the Plan and you wish to use pre-tax dollars to pay for medical care coverage offered through the Health Connector, you must complete a Participation Election Form within 30 days following the date you become eligible. You will also need to select a medical care coverage plan and complete an enrollment form. This must be done through the Health Connector. More than one method of enrollment may be available, such as a written enrollment form, electronic enrollment on an internet web site or via telephone. For more information on medical care coverage options offered through the Health Connector and/or to enroll in medical care coverage, please visit the Health Connector’s website at [www.MAhealthconnector.org](http://www.MAhealthconnector.org).

Your participation in the Plan will be effective [ ] and will remain in effect until you cancel it or you otherwise become ineligible to participate in the Plan.

If you are eligible to participate in the Plan but you decide not to use pre-tax dollars to pay for medical care coverage, or you do not enroll in medical care coverage within 30 days following the date you become eligible, you will be deemed to be a participant in the Plan who has elected the cash option. This means that, absent a change in status event (described in the next section below), you will not be

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<sup>2</sup> [This needs to be customized by the employer based on the employer’s eligibility requirements.]

able to elect to use pre-tax dollars to purchase medical care coverage until the Plan's next annual enrollment period.

Before the start of each Plan Year (e.g. July 1 - June 30), you will be offered an annual enrollment period to change your existing election. If you do not make a new election, your existing election will remain in effect.

## **Changing Your Election**

Generally, you cannot change the elections you have made under the Plan after the beginning of the Plan Year. However, you are permitted to change certain elections if you experience an IRS defined "change in status" and/or other special events as described below.

Examples of status changes include these events:

- marriage;
- divorce, legal separation or annulment;
- death of your spouse or dependent child;
- birth, adoption or placement for adoption of a child;
- termination of the employment of your spouse or dependent child;
- commencement of the employment of your spouse or dependent child;
- your or your spouse's or dependent child's commencement or return from an unpaid leave of absence from employment;
- adjustment to your or your spouse's or dependent child's work schedule, such as a switch between part-time and full-time work, a strike, a lockout or an increase or reduction in hours of employment, that causes a loss of coverage;
- a change in your or your spouse's or dependent child's worksite or residence that causes a loss of current coverage eligibility;
- adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify as a dependent under the Plan;
- significant change in your or your spouse's health coverage attributable to the spouse's employment; and
- leave of absence under the Family Medical and Leave Act.

Your election may also be changed if one of these special events occurs:

- the issuance of a judgment, decree or order that requires accident or health coverage for your dependent child.
- your or your spouse's or dependent child's entitlement to Medicare or Medicaid that causes a loss of coverage.
- a "significant" increase in the cost of any benefit under the Plan.
- elimination or "significant" cutback in coverage provided by an insurance company or other third party. You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change.
- your failure to make the required premium payment. Your election will be canceled but you will not be able to make a new election for the rest of the Plan Year.
- your separation from service. If you terminate employment, you may cancel your election for any remaining period of coverage.

If you have a status change and/or other special event and you want to cancel or modify your election for the remainder of a Plan Year, you must file a request with your Employer within 30 days of the event. Keep in mind that any change to your election must be consistent with your status change. Your Employer will consider your application and inform you of the decision.

All change requests received more than 30 days after the date the event occurred will not be processed. To make the change after this 30 day period, you will have to wait until the next annual enrollment period or a subsequent status change event, whichever occurs sooner.

### **Individuals Not Covered By This Plan**

There are certain instances where an individual is a dependent for medical care coverage purposes but may not be your dependent for purposes of this Plan. For example, if you cannot claim the individual as a dependent on your federal income tax return, but the individual is eligible for coverage under your medical care coverage, the value of the medical coverage for this individual must be paid on an after-tax basis. In addition, domestic partners and same sex spouses are not eligible for the favorable tax treatment unless you can claim them as dependents on your federal income tax return.

### **Participation While On Leave**

If you take a leave of absence for your own serious health condition or to care for family members with a serious health condition or to care for a newborn or adopted child, you may be able to revoke your election. If you revoke your election, you may also reinstate your election when you return to work. See your Employer for more information about your rights.

## Termination Of Employment

If you stop working for your Employer, you will no longer be eligible to participate in this Plan and your election to participate will automatically terminate. This means that your medical care coverage premiums payable after you stop working for your Employer will be paid for on an after-tax basis (unless you subsequently become employed and enroll in another employer's cafeteria plan). In the event you become a participant in this Plan again within 30 days of the date you stopped being a participant and before the end of the same Plan Year, the elections you previously had in effect will automatically be reinstated for the balance of the Plan Year.

Keep in mind, your termination of employment does not affect your underlying medical care coverage. You can keep your medical care coverage in effect by simply continuing to make the required monthly premium contributions by sending after-tax payment directly to the Health Connector by the applicable due date.

## Questions

If you have any questions or would like additional information, you can contact [the Employer] at [\_\_\_\_\_].

## Appendix C-4 - Board of Directors Consent Form

[COMPANY NAME]

(the "Company")

\_\_\_\_\_

ACTION BY UNANIMOUS CONSENT

IN LIEU OF MEETING OF DIRECTORS

\_\_\_\_\_

Dated: \_\_\_\_\_

The undersigned, being all of the Directors of the Company, a Massachusetts Corporation, do hereby consent in writing to the actions set forth in the form of votes immediately following, which shall be treated as votes for all purposes, as fully as if said actions and votes had been adopted at a duly called and held meeting of the Board of Directors of the Company (the "Board").

VOTED: That the Board hereby approves and ratifies the adoption of the Premium Only Section 125 Cafeteria Plan (the "Plan"), effective [\_\_\_\_\_], in the form attached hereto as Exhibit A, the execution and delivery thereof to be conclusive evidence that the same were authorized by this vote;

VOTED: That the officers of the Company be, and each of them acting singly hereby is, authorized, empowered and directed, in the name and on behalf of the Company, to take any and all actions and to execute or cause to be executed such documents, agreements or other instruments as shall be necessary, convenient or desirable to carry out the intent and purposes of the foregoing votes; and

VOTED: That the officers of the Company be, and each of them acting singly hereby is, authorized to take any and all actions necessary, including but not limited to adopting amendments to the Plan, to comply with Section 125 of the Internal Revenue Code of 1986 and M.G.L. c. 151F and 956 CMR 4.00.

This written consent may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

DIRECTORS:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Appendix C-5 - Employee Waiver /Election Form/ Compensation Reduction Agreement

(ENTER COMPANY NAME) SECTION 125 CAFETERIA PLAN

This form must be completed when an employee elects to either a) waive all pre-tax benefits or b) enroll in a pre-tax benefit deducted from their compensation for their medical care coverage premium amount.

\_\_\_\_\_  
Employer Name (Legal Entity Name)

\_\_\_\_\_  
Employee Name (First, Middle Initial, Last)

\_\_\_\_\_  
Employee Address

\_\_\_\_\_  
Employee Social Security Number

\_\_\_\_\_  
Employee Number/ID

Plan Year \_\_\_\_\_ through \_\_\_\_\_

**Waiver of Pre-Tax Benefits**

I elect to waive all pre-tax benefits under the Section 125 Cafeteria Plan:

I understand that if I have enrolled for medical care coverage on a separate benefit enrollment form, I will pay the required contribution with after-tax payroll deductions. I understand that I cannot elect pre-tax benefits except and until as described below and any after-tax medical care coverage is outside the Plan.

Prior to each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this election to waive participation as indicated above.

**Election of Pre-Tax Benefits**

I understand that an amount equal to the annual contributions for the coverage I have elected, divided by the number of pay periods in the Plan Year, will be deducted on a pre-tax basis from

each of my paychecks (unless another method is prescribed by the Plan Administrator) to pay for the coverage that I elect.

### Election For Medical Care Coverage

On a separate enrollment form(s), I have enrolled in medical care coverage and I have received a schedule showing my share of the contributions for such coverage.

In accordance with my rights under the Plan, I authorize salary reductions in the amount of current premiums being charged for the medical care coverage I have elected as follows:

Medical Care Coverage \_\_\_\_\_ Premium per Month \$ \_\_\_\_\_  
(Enter Connector Seal of Approval Plan Name from Enrollment Form)

I understand that:

- If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reductions will automatically be adjusted to reflect that increase or decrease.
- The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.
- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefits programs maintained by my employer.
- Pre-tax contributions are not subject to federal income or Social Security (“FICA”) taxes. This could result in a reduction in the Social Security benefits I receive at retirement if I earn less than the annual FICA “taxable wage base” (\$97,500 for 2007).
- Prior to the first day of each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this benefit election for the new Plan Year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the benefit option for the new Plan Year.
- This Agreement is subject to the terms of the employer’s Section 125 cafeteria plan, as amended for time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Accepted and agreed to by the Employer’s Authorized Representative:

\_\_\_\_\_  
By

\_\_\_\_\_  
Date

## Appendix C-6 - Employee Revocation/Change in Status Certification

(ENTER COMPANY NAME) SECTION 125 CAFETERIA PLAN

\_\_\_\_\_  
Employer Name (Legal Entity Name)

\_\_\_\_\_  
Employee Name (First, Middle Initial, Last)

\_\_\_\_\_  
Employee Address

\_\_\_\_\_  
Employee Social Security Number

\_\_\_\_\_  
Employee Number/ID

Plan Year \_\_\_\_\_ through \_\_\_\_\_

As a participant in the Cafeteria (Plan), I am entitled to revoke my current benefit election and enter into a new election in the event I incur certain changes in status permitted by the terms of the Plan.

I hereby revoke my election effective: \_\_\_\_\_.

I understand that any change in my benefit election must be necessitated by and consistent with the change in status as defined in the Plan and certified by me below:

I certify that I have incurred the following change in status:

- Marriage
- Birth of Child, Adoption of Child
- Divorce, Legal Separation or Annulment
- Dependent Attending School
- Moved out of service area for myself, my spouse or dependent
- Death of my spouse and/or dependent

- Switching from part-time to full-time (or vice-versa) employment on the part of me or my spouse, or dependent or reduction or increase in hours, strike or lockout
- Termination or commencement of employment by my spouse or dependent
- Other permissible event: \_\_\_\_\_

Date that the change in status occurred (MM/DD/YYYY): \_\_\_\_\_

The Administrator may require you to provide evidence to document the event which requires the change of election.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Administrator

\_\_\_\_\_  
Date