TRUCKER ✦ HUSS

BENEFITS REPORT

SEPTEMBER 2015

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A PROFESSIONAL CORPORATION

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# At Last! IRS Issues Final ACA Reporting Instructions and Forms for Employers and Providers of "Minimum Essential Coverage"

TIFFANY N. SANTOS

On September 16, 2015, after several draft iterations, the IRS issued the long awaited:

- Final 2015 Forms 1094-C and 1095-C (and related instructions) for "applicable large employers" to report coverage offered to their full-time employees to allow the IRS to determine whether the employer owes a payment under the employer shared responsibility provisions of Section 4980H of the Internal Revenue Code (the "Code); and
- Final 2015 Forms 1094-B and 1095-B (and related instructions) for providers of "minimum essential coverage" ("MEC"), such as health insurance issuers and multiemployer trusts sponsoring self-funded plans, to report coverage provided to covered individuals to help the IRS determine if the individual is liable for the individual shared responsibility payment under Section 5000A of the Code.

The IRS also issued Notice 2015-68 announcing its intent to propose regulations further implementing the reporting requirement under Section 6055 of the Internal Revenue Code for MEC providers.

While the final instructions for the most part track the requirements of the draft instructions (see our August 2015 and May 2015 newsletters for a discussion of these requirements), they include the following significant changes:

- **Simpler Reporting of Coverage Offered under a Multiemployer Plan in 2015:** If an employer relies on the multiemployer plan interim guidance and, therefore, enters "2E" on line 16 for any month in Part II of the Form 1095-C, it may now enter "1H" on line 14 for the corresponding

month irrespective of whether the employee was eligible to enroll or enrolled in coverage under the multiemployer plan. This means that an employer is no longer required to obtain information from the multiemployer plan to determine if any of its employees were actually enrolled in the plan.[1] To claim this relief with respect to a full-time employee, an employer must be required to contribute to a plan that meets the "affordability" and "minimum value" requirements of Section 4980H of the Code on that employee's behalf under the terms of a collective bargaining agreement.

- **COBRA Elected by Terminated Employees Need Not Be Reported:** Departing from the draft instructions, the final Form 1095-C instructions no longer require an employer to report COBRA continuation coverage that is offered to a terminated employee. The "no offer of coverage" code (*i.e.*, "1H") may now be entered on line 14 for any month that that COBRA was offered with the corresponding "not an employee" code "2A" on line 16 for that month.
- **HRA Coverage Need Not Be Reported if Employee Is Also Covered by Employer's Medical Plan:** In a departure from the draft August 2015 instructions, the final Forms 1094-B and 1095-B instructions state that if an employee is covered by more than one MEC, for example a "health reimbursement arrangement" or "HRA" and a self-funded or insured major medical plan sponsored by the same employer, only one of the coverages must be reported. This means that if an employer offers an HRA to employees who are also enrolled in the insured medical plan sponsored by the same employer, the employer is not required to report the HRA coverage as the insurance carrier will report the insured coverage. An employer, however, must report HRA coverage if the employee's medical coverage is provided through another employer's plan (for example, a spouse's plan).
- **Filing Extension:** The final instructions confirm that an automatic 30-day extension of the time to file the Forms 1094-B/1095-B or 1094-C/1095-C with the IRS is available with the submission of the Form 8809 by the due date of the applicable return (by February 29, 2016 or March 31, 2016 if filing electronically). No signature or explanation is necessary to obtain this extension. With respect to the time for furnishing the Form 1095-C to employees (*i.e.*, February 1, 2016 for 2015 returns), a 30-day extension is available only if a letter signed by the filer is sent to the IRS with the reason for the delay and the IRS approves the request.
- **Waiver from Electronic Filing Requirement:** Recognizing that filers may not be able to file electronic returns, the instructions allow filers to apply for a waiver by filing the Form 8508 at least 45 days before the due date of the returns. Electronic filing with the IRS is required if the entity must file 250 or more information returns and the entity has not received an approved waiver.
- **Corrected Returns:** As described in our prior newsletters, relief from the filing penalties is available if the filer timely submits 2015 returns with incorrect or incomplete information and can show a good faith effort to comply with the filing requirements. However, as the filing instructions include the process for filing corrected returns, it appears that the IRS expects filers to submit corrected 2015 returns to the IRS and to the affected employee, as applicable, once the filer discovers an error and has the information to correct the error, to avoid penalties.

In Notice 2015-68, the IRS announced its intent to propose rulemaking under Section 6055 of the Code on the following:

- To require reporting in 2017 by Exchanges of "catastrophic coverage" purchased by individuals in 2016;
- To allow insurers that file and furnish the Forms 1094-B and 1095-C, to use a truncated taxpayer identification number for the employer sponsoring the plan on the statement furnished to the individual taxpayer (*i.e.*, the Form 1095-B);
- To allow filers to electronically furnish the Form 1095-B statement to individuals covered by an expatriate plan;

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[1] While the prior draft instructions state that the code indicating that the employee was enrolled in coverage (*i.e.*, "2C") supersedes all other codes, including the code for multiemployer plan relief (*i.e.*, "2E"), the final instructions eliminate this rule.

- To confirm that reporting of MEC that supplements or provides benefits in addition to other MEC (for example, HRA coverage that is integrated with self-insured or insured major medical coverage) is not required if the primary and supplemental coverage have the same plan sponsor or the coverage supplements government-sponsored coverage such as Medicare or Tricare;
- Penalty relief under the "reasonable good cause rules" relating to the requirement to report and solicit, as applicable, taxpayer identification numbers ("TIN") (note: until additional guidance is issued, the Notice states that no penalties will be imposed for failing to report an individual's TIN if: (a) the initial solicitation for the individual's TIN is made at the individual's initial enrollment or, if already enrolled on September 17, 2015, the next open season; (b) the second solicitation is made at a reasonable time thereafter; and (c) the third solicitation is made by December 31 of the year following the initial solicitation.

If you have any questions regarding the foregoing, please contact the author of this article.

## New IRS Proposed Regulations Defining Minimum Value for Employer Shared Responsibility Provisions

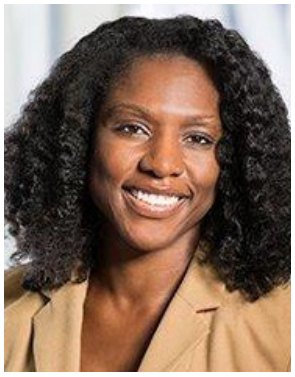
### JENNIFER TRUONG

On September 1, 2015, the Internal Revenue Service ("IRS") issued new proposed regulations on the determination of whether an employer-sponsored health plan provides "minimum value," for purposes of the employer "offer of coverage requirement under Section 4980H of the Internal Revenue Code Under the proposed regulations and consistent with IRS Notice 2014-69, a health plan provides minimum value only if (1) the plan covers at least 60% of the total allowed costs of benefits that are expected to be provided under the plan and (2) plan benefits include substantial coverage of inpatient hospital services and physician services. Notice 2014-69 was previously issued to address a "loophole" that allowed "skinny plans" that did not cover in-patient hospital stays or provided limited coverage for such services to meet the "minimum value" requirement via the Department of Health and Human Services's "minimum value calculator." That calculator did not require a plan to input the coverage available for inpatient hospitalization to determine if the plan met the 60% actuarial value minimum and, as a consequence, allowed plans that excluded coverage for such services to satisfy the "minimum value" standard.

Proposed to apply to plan years beginning after November 3, 2014, the regulations apply immediately, even for plans that are in the middle of a plan year. However, limited transition relief is available for plans that do not currently provide substantial coverage of hospital and physician services if the employer plan sponsor entered into a binding written commitment to adopt the non-compliant plan terms, or began enrolling employees in a noncompliant plan, before November 4, 2014. Such "skinny plans" have until the plan year beginning on or after March 2, 2015 to comply with the requirement to provide substantial coverage for inpatient hospitalization and physician services.

Although the proposed regulations do not state what approach the agency will likely take in defining "substantial coverage," the IRS has requested comments on potential rules for determining substantial coverage by November 2, 2015.

# IRS Issues Final Regulations on the Determination of Minimum Required Contributions for Single Employer Defined Benefit Plans



T. KATURI KAYE

On September 9, 2015, the Internal Revenue Service ("IRS") issued final regulations on determining minimum required pension contributions under Internal Revenue Code ("Code") section 430 for single employer defined benefit pension plans for plan years beginning on or after January 1, 2016. Code section 430 was added by the Pension Protection Act of 2006 ("PPA"), as amended by the Worker, Retiree, and Employer Recovery Act of 2008 ("WRERA"), the Moving Ahead for Progress in the 21st Century Act of 2012 ("MAP–21") and the Highway and Transportation Funding Act of 2014 ("HATFA"). The final regulations also reflect guidance on the excise tax for failure to satisfy the minimum funding requirements for both single employer and multiemployer defined benefit pension plans under Code section 4971, as amended by the Cooperative and Small Employer Charity Pension Flexibility Act of 2014 ("CSEC Act"). This article highlights some of the key provisions of the final regulations.

## Background

Code section 430 sets forth the minimum funding requirements that apply to single employer defined benefit plans (which, for these purposes, include multiple employer plans) pursuant to Code section 412. Generally, the amount of the minimum required contributions for the plan year is determined by comparing the value of plan assets (less the sum of the plan's prefunding balance and funding standard carryover balance) to its funding target. If the value of plan assets is less than the funding target, Code section 430 defines the minimum required contributions as the sum of the plan's target normal cost and the shortfall and waiver amortization charges for the plan year. If the value of plan assets equals or exceeds the funding target, Code section 430 defines the minimum required contribution as the plan's target normal cost for the plan year reduced (but not below zero) by the amount of the excess. Code section 430 also addresses how to determine the shortfall amortization base and the interest rates that must be used in determining a plan's target normal cost and funding target.

Under Code section 430(j), the due date for payment of any minimum required contributions for a plan year is eight and one-half months (8 1/2) after the end of the plan year. Generally, any payment made on a date other than the valuation date for the plan year must be adjusted for interest accruing at the plan's effective interest rate under Code section 430(h)(2)(A) for the plan year for the period between the valuation date and the payment date. Under Code section 430(j)(3), if the plan had a funding shortfall for the preceding plan year, the plan sponsor must pay certain quarterly installments toward the required minimum contributions for the plan year. Each quarterly installment is generally twenty-five percent (25%) of the required annual payment. If a quarterly installment is made after the applicable due date, then the interest rate that applies for the underpayment period is the plan's effective interest rate plus five percentage points.

Code section 4971(a) imposes an excise tax on the employer for a failure to meet its applicable minimum funding requirements. In the case of a single-employer pension plan, the tax is generally ten percent (10%) of the aggregate unpaid minimum required contributions for all plan years remaining unpaid, as of the end of any plan year ending with or within a taxable year.

On April 15, 2008, the IRS proposed rules providing plan sponsors of single employer defined benefit plans with guidance on minimum required contributions under Code section 430 and the applicable excise taxes under Code section 4971, as summarized above. The final regulations are similar to the proposed regulations, but make some changes, including changes to reflect WRERA, the CSEC Act and HATFA.

## Highlights of the Additions or Changes in the Final Regulations

The additions or changes in the final regulations include the following:

- Under the proposed regulations, liquidity shortfalls could only be corrected through contributions, and the excise tax would apply for every quarter until the liquidity shortfall for a quarter was corrected through contributions. In response to comments, the final regulations provide that a payment of the liquidity shortfall is treated as unpaid until the close of the quarter in which the due date for the installment occurs (without regard to any contribution of liquid assets that is made after the due date of the required installment).
- In response to comments, the final regulations provide a special rule for applying the liquidity requirement to multiple employer plans. Under these rules, the liquidity requirement is treated as satisfied if the requirement would be satisfied if the plan was a single employer plan. If it is not satisfied on that basis then the rules must be applied separately to each employer under the plan, as if each employer sponsored its own plan.
- The proposed regulations provided that contributions are first treated as satisfying the quarterly installment requirement without regard to the liquidity requirement. So that all contributions of liquid assets apply toward satisfaction of the liquidity requirement, the final regulations provide that any contribution of liquid assets for a quarter applies toward satisfying the liquidity requirement (as well as the otherwise applicable quarterly installment).
- The final regulations clarify that if a plan terminates before the last day of a plan year, the plan is treated as having a short plan year that ends on the termination date. As a result, the minimum required contribution for such a plan is determined based on that short plan year. If a plan terminates before the date that would otherwise have been the valuation date for a plan year, then the valuation date for the plan year must be changed so that it falls within the short plan year. Also, any minimum required contributions for the year of plan termination is due eight and one-half (8½) months after the termination date.
- The final regulations add a technical correction to the first segment interest rate in Code section 430(h)(2)(B)(i) to reflect modifications made under section 2003(d) of HATFA. The final regulations also add an interest credit at the plan's effective interest rate on a contribution made to meet a required quarterly installment for the period from the contribution payment date to the due date for the installment, which is intended to reduce the amount that needs to be contributed when making payments in advance of a due date.
- The final regulations permit a plan sponsor to provide the plan's enrolled actuary with a written standing election to use the plan's prefunding and carryover balances to satisfy quarterly contribution obligations. This standing election is deemed effective on the later of the last date for making the required quarterly contribution and the date the standing election is provided to the enrolled actuary. The standing election remains in effect until revoked, suspended, or replaced, or until the enrolled actuary is changed. A standing election may need to be revised once the minimum required contribution for the year is determined.
- The final regulations set forth definitions that apply for purposes of applying the excise tax rules of Code section 4971, which are substantially the same as the definitions in the proposed regulations but include certain modifications reflect the CSEC Act.

## Effective Date

The final regulations were effective on September 9, 2015, and apply to plan years beginning on and after January 1, 2016. However, for plan years beginning before 2016 and after 2007, a plan sponsor may rely on either these final regulations or the proposed regulations published in 2008.

## Conclusion

The final regulations under Code section 430 are highly technical and include detailed instructions for plan sponsors and actuaries beyond what is addressed in this article. Sponsors of single-employer defined benefit plans should review the final regulations with their actuary to determine whether and how they affect their plans and funding policy.

# Must Benefit Denial Letters Inform Claimants of a Plan's Time Limit for Bringing a Lawsuit?

CLARISSA A. KANG

"Yes," says the U.S. Court of Appeals for the Third Circuit. The Third Circuit in *Mirza v. Insurance Administrator of America, Inc., et al.* recently held that a plan administrator violated section 503 of the Employee Retirement Income Security Act of 1974 ("ERISA") for failing to disclose in a benefits appeal denial the plan's 12 month limitations period for a claimant to bring a lawsuit on the benefits denial. The recent Third Circuit ruling confirms a best practice for benefit plan administrators: if your plan document designates a certain period of time by which a claimant can bring a lawsuit on a denied benefit claim, you should include a notice of such deadline in your benefit denial letters.

## DOL Claims Procedures Require Certain Key Elements in Benefit Determination Notifications

In ERISA section 503, Congress granted the U.S. Department of Labor ("DOL") the authority to create regulations that set forth procedures for determining benefit claims and to afford claimants an internal right of appeal. The claims regulations promulgated by the DOL under ERISA section 503 require, among other things, that a plan administrator who denies a request for benefits to set forth in the initial claim denial a "description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimants' right to bring a civil action . . ." 29 C.F.R. § 2560.503-1(g)(1)(iv).

## Plans Can Specify a Deadline by which a Lawsuit for Recovery of Benefits Must Commence

ERISA does not provide a statute of limitations for lawsuits brought under section 502(a)(1)(B) of ERISA to recover benefits. The only statute of limitations contained in ERISA (ERISA section 413) is for a breach of fiduciary duty claim. In light of ERISA's silence on a limitations period for benefits claims, courts borrow the most closely analogous state statute of limitations — typically a breach of written contract statute of limitations — and apply that to the action for benefits. Plans can choose to specify a different limitations period, and often specify a shorter limitations period than the analogous state statute of limitations. The U.S. Supreme Court in *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S.Ct. 604 (2013), upheld a limitations period contained in a plan document where the limitations period is not unreasonably short and no controlling statute prevented the limitations provision from taking effect.

## The District Court Held Mirza's Benefits Lawsuit Was Time-Barred

In *Mirza*, the federal district court for the District of New Jersey upheld the plan document's 12 month limitations period, finding that the plan administrator did not violate ERISA section 503 or the DOL's claims regulations for not including the plan-imposed deadline to seek judicial review in the benefit denial letters. (The Third Circuit ultimately disagreed.)

Dr. Neville Mirza was a medical provider who treated N.G. and to whom N.G. assigned the right to pursue a benefit claim from the health plan in which N.G. participated. Mirza brought an action to recover payment of the denied $34,500 benefit claim from Insurance Administrator of America, Inc. ("IAA") (the plan's claims administrator) and Challenge Printing Company of the Carolinas, Inc. ("Challenge") (the plan sponsor).

The Challenge plan provided that "no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered)." Mirza submitted a claim for medical services to IAA for payment under the Plan for services provided to N.G. IAA denied the claim, and Mirza subsequently appealed that denial through two levels of appeal. On August 12, 2010, IAA sent Mirza a final written

determination denying his claim and advising him that he had a right to bring a civil action under ERISA section 502(a). None of IAA's written determinations of the benefit claim or appeal stated that, under the Plan, the claimant had only 12 months to bring a civil action under ERISA section 502(a), despite the appeal denial letter's statement that the claimant had a right to bring a civil action under Section 502(a). Mirza engaged The Law Office of Sean R. Callagy (the "Callagy Firm") sometime between the final appeal denial letter in August 2010 and February 10, 2011.

Around the same time that Mirza had submitted a claim and appeal, IAA also handled a separate appeal from another provider, Spine Orthopedics Sports ("SOS"), for the same Plan participant, N.G., and the same Plan. The Callagy Firm (which represented Mirza) represented SOS during the appeal process. During the course of SOS's pursuit of a claim and an appeal, on November 23, 2010 (some 3 months after Mirza received a final determination on his appeal from IAA), IAA advised a member of the Callagy Firm that the Plan had a one year contractual statute of limitations to initiate a civil action. IAA finally denied SOS's appeal on April 11, 2011 and provided a copy of the Plan with the denial letter.

The Callagy Firm on behalf of Mirza commenced a lawsuit stemming from the denial of benefits under the Plan on March 8, 2012. IAA and Challenge moved for summary judgment on the grounds that Mirza's action was time-barred by the Plan's 12 month statute of limitations.

The district court held that the 12 month time limit specified in the plan was not manifestly unreasonably and was therefore enforceable. The district court rejected Mirza's argument that IAA's failure to advise Mirza of the plan's deadline for claimants to seek judicial review in the final denial letter equitably tolled the plan's time limitation.

## The Third Circuit Holds that the DOL Claims Regulations Require Written Disclosure of Plan-Imposed Time Limits on the Right to Bring a Civil Action

On appeal, the Third Circuit reversed and remanded the decision by the district court. The Third Circuit held that plan administrators must inform claimants of plan-imposed deadlines for judicial review in their benefit denial letters. Where the plan administrator fails to do so, the Third Circuit held that a court should set aside the plan's time limit and apply the limitations period from the most analogous state-law cause of action. Applying New Jersey's six year statute of limitations for breach of contract claims, the Third Circuit held that Mirza filed his complaint within the statutory limitations period.

Unlike the district court, the Third Circuit focused its analysis not on equitable tolling but instead on whether defendants violated the DOL claims regulations in failing to including the plan's 12 month time limit for seeking judicial review in the benefit denial letter. The relevant regulatory provision at 29 C.F.R. § 2560.503-1(g)(1)(iv) requires that an administrator set forth a "description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination." IAA and Challenge argued that the regulatory provision refers to two separate requirements — (1) notice of the plan's review procedures and the time limits for those procedures and (2) notice of the right to sue. The Third Circuit disagreed with the defendants' view, finding that the defendants' arguments ignored the word "including." To the extent the regulatory provision was ambiguous, the Third Circuit held that it was obligated to construe it broadly and in favor of Mirza "because ERISA is a remedial statute."

In holding that the defendants had violated the regulatory provision, the Third Circuit noted that its interpretation of the regulation was consistent with that of the First and Sixth Circuit Courts of Appeals in *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675 (1st Cir. 2011) and *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014). Both the First and Sixth Circuit held that the regulation included the right to bring a civil action as part of the procedures for which time limits must be provided. The Third Circuit distinguished the rulings that upheld plan-imposed limitations periods even though the denial letters did not include notification of the limitations period in Second and Ninth Circuit Courts of Appeal in *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 496 F. App'x 129 (2d Cir. 2012), and *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009), on the basis that those other Circuit court decisions were decided under federal com-

mon law and the court did not interpret the DOL claims regulations. The Third Circuit noted that in *Scharff*, the plaintiff did not rely on the language of the DOL claims regulations to argue that defendant's failure to disclose the plan's contractual limitations period in a denial letter violated a regulatory requirement and instead argued that the defendant violated the doctrine of "reasonable expectations" under federal common law. The Ninth Circuit held that the defendant's disclosures in other documents were sufficient to not run afoul of the reasonable expectations doctrine. In *Heimeshoff*, which was later appealed to the Supreme Court, the Second Circuit chose not to base its decision on the DOL claims regulations and instead held that the plaintiff in that case had notice of the limitation and was therefore not entitled to equitable tolling.

The Third Circuit pointed out certain practical considerations for its interpretation of the regulation. First, it felt that if defendants were not required to disclose a plan-imposed time limit for seeking judicial review of a denied benefit claim, plan administrators could bury the limitation period in a lengthy plan document and not have any obligation to disclose it in a significantly shorter claim denial letter that the participant was more likely to read. The Third Circuit also believed that by not including a statute of limitations in ERISA for benefit claims, Congress delegated the authority to plan administrators and fiduciaries to develop their own deadlines for judicial review and the DOL thought it important to ensure that benefit denial letters informed claimants of deadlines for judicial review in the benefit denial letters. It felt that the requirement to inform claimants of the plan-imposed time limit to bring a lawsuit imposed but a "trivial burden" on plan administrators. The Third Circuit held, following the Sixth Circuit's decision in *Moyer*, that failure to so inform claimants renders the adverse benefit determination not in substantial compliance with ERISA section 503.

The Third Circuit found no need to apply equitable tolling and found no need to reach the issue of whether Mirza, through his law firm's work on another provider's claim, was on notice of the plan's contractual limitations period. It felt that if court allowed plan administrators argue that claimants were on notice of the contractual limitations period or otherwise failed to exercise reasonable diligence, plan administrators would have no reason to comply with the DOL claims regulations which the Third Circuit believed required disclosure of the plan-imposed deadline in the adverse benefit determination. The Third Circuit held that the proper remedy was to set aside the plan's 12 month limitations period for filing a lawsuit and to instead apply New Jersey's six-year breach of contract statute of limitations. It reversed the district court's decision and remanded the case back to the district court for further proceedings.

## Circuit Split

The Third Circuit's opinion deepens a split among the federal courts of appeals on the disclosure question. The Third Circuit agreed with the federal Courts of Appeals for the First and Sixth Circuits that plan administrators must inform participants of any plan-imposed deadline for bringing a civil action under ERISA section 502 in the benefit denial letters. The Ninth Circuit in *Scharff* and Eleventh Circuit in *Wilson v. Standard Insurance Co.*, 2015 WL 3477864 (11th Cir. June 3, 2015), have previously ruled the other way. In the face of disagreement among the federal courts of appeals, the issue may be one that the Supreme Court will eventually choose to decide.

## Best Practice

Many plans have their own contractual limitations period for suing on a denied benefit claim, especially after the Supreme Court's ruling in *Heimeshoff* upheld the enforceability of plan-imposed deadlines to request judicial review. The contractual limitations periods often are shorter than the analogous state statute of limitations that courts would apply to an ERISA benefits claim, and in that way, the contractual limitations periods provide earlier closure to disputes over benefits and thereby added security to plan administrators and plan sponsors. For those plans that have limitations periods for judicial review written into the plan document, we think the Third Circuit ruling offers an opportunity to further protect plan fiduciaries by improving the content of benefit denial letters — even those plan fiduciaries that are in jurisdictions outside of the Third Circuit. Although the courts of appeals disagree as to whether the DOL claims regulations require disclosure of a plan's contractual limitations period, we think that the best practice — the safest practice — is for plan administrators to disclose any plan-imposed deadlines in the benefit claims and appeal denial letters.

## FIRM NEWS

On September 29, **Mary Powell** and **Elizabeth Loh** presented a webinar entitled, *The Deadline for Filing Forms 1094-C AND 1095-C is Quickly Approaching. Are You Prepared?*

On September 29, **Marc Fosse** and **Callan Carter** spoke at a Bar Association of San Francisco Taxation Section event entitled: *Year-End ACA, Equity and Executive Compensation Action Items.*

On October 1, **Callan Carter** presented on wellness benefits at the California Employment Law Update conference at the Claremont Hotel in Berkeley.

On October 18, **Brad Huss** will be speaking at a workshop entitled *Fiduciary Case Studies* at the 2015 ASPPA Annual Conference.

On October 28-30, 2015 **Clarissa Kang** will be speaking on three panels at the American Bar Association's 29th Annual National Institute on ERISA Basics in Chicago.

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