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GROUP INSURANCE

Specializing in Schools, Unions, Public and Private Entities



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President's Corner



Welcome to the fall edition of the newsletter. I hope you all had a great summer, and are ready to tackle the challenges that come with heading into a new year.

This issue of the newsletter contains IMPORTANT information regarding new IRS regulations regarding Over The Counter drugs and medicines and how they will be covered under Flexible Spending Plans effective January 1, 2011. I urge you to familiarize yourself with these changes, as they will impact how you and your employees plan for flex spending payroll deductions.

We've also included some informative material regarding the waiver of premium clause found in most group life insurance policies, and how the option can save you money, and protect your employees' benefits in the event of disability.

Thanks for taking the time to read the newsletter, and feel free to call us if we can be of help with the administration of your group benefit plans.

Jim

Save Money and Protect Your Employees' Life Insurance Coverage by Taking Advantage of Your Policy's "Waiver Of Premium" Clause.

By Cathy Robinson, Sales and Marketing Assistant

Why would an employer pay a life insurance premium on an employee if it were possible to have that premium waived? It sounds like a "no brainer", yet employers continue to carry employees who are disabled on their group life insurance policies as "active" employees. Most group life policies contain a waiver of premium clause for insureds who are not actively at work due to a disability. This clause can save employers a substantial sum of money.

In addition, if the employer should change carriers, these disabled employees risk losing their life insurance benefit because they were not actively at work when the new policy became effective. If the employee were properly

classified as disabled, the prior carrier would continue to be responsible for any claims in the event of the employee's death. All that's needed to assure that benefits are continued is to have the employee complete a waiver of premium application and submit it to your carrier. If the employee meets the criteria of the carrier to be classified as disabled, the premium is waived and the employee is guaranteed benefits through your current carrier if you change to a new carrier.

We urge you to review the eligibility status of each of your employees and encourage all who are, or become, disabled to complete a waiver of premium application if they have not already done so. You will save money on premium and your employees and their families will have the protection they are relying upon.

- Student Accident
- Self Funded Worker's Compensation
- Worker's Compensation
- Property and Casualty
- Group Health Insurance
- Group Life Insurance
- Group Long Term Disability
- Vision Insurance
- Short Term Disability
- Dental Insurance
- Self-Funded-Dental and Vision
- Excess Major Medical (EMM) Consulting
- Section 125 Flexible Spending Plan
- HRA Administration
- Transit Reimbursement
- Billing of active and retired participants
- Claims Administration
- Management of the open enrollment process
- Claims Access

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Voluntary Benefits: A Win-Win that Satisfies Employee Interests and Employer Needs



The voluntary benefits market is growing, and with good reason. Voluntary benefits—offered through the workplace but paid for fully by employees—enable an employer to make a wide array of supplemental benefits available to employees, at little or no cost to the company. Voluntary benefits products are so attractive that, according to one study, more than six in ten employers now offer at least one type of voluntary benefit.

The advantages of voluntary benefits are well known. Because a voluntary benefit product is marketed and sold in a group setting, employees can purchase the benefits at a group rate, pay for them through payroll deduction, and save the time of shopping for them on their own.

For eight consecutive years, MetLife has conducted research on employees and employers regarding the U.S. benefits industry, and compiled the results in its annual Study of Employee Benefits Trends. The 2010 study reveals the apparent resilience of workplace benefits even during a tough economy. It also shows that although employers and employees continue to deal with the effects of the economic downturn, they are focused on the long term, and value voluntary benefits. However, there is a slight disconnect on how much worth employers/employees place on voluntary benefits.

According to the 2010 study, 57% of employees agree that voluntary benefits provide access to options that better fit their needs. Furthermore, 60% of employees surveyed believe that voluntary benefits are valuable to provide them with extra coverage that supplements employer-sponsored benefits.

From the employer's perspective, the study found that many employers underestimate the value employees place on voluntary benefits. Just as employees expressed greater interest in voluntary benefits, the importance of these benefits has declined among employers. As a result, there may be a missed opportunity for employers to improve satisfaction with benefits program.

The most in-demand voluntary benefits continue to be those that supplement core medical, life, or disability coverages. These include dental, critical illness, specific illness, hospital supplemental, medical supplemental, disability buy-up, and supplemental life coverages. However, demographic trends are contributing to growing interest in long-term care and financial planning

products. As more people become faced with their parents' eldercare needs, they begin to appreciate the cost of extended care and anticipate what their own needs may be in a few short years. And, many workers, beginning in mid-career, face the double crunch of saving for retirement at the same time they are attempting to finance their children's college education.

Other products in the voluntary benefits market include vision insurance, legal services plans, auto/homeowners'/renters' insurance, and pet care insurance.

In deciding upon a particular voluntary benefit product or vendor, an employer should keep several things in mind:



- Is the type of product one for which employees have expressed an interest (as demonstrated by requests made or surveys done of the workforce) or one that you are comfortably sure employees will want?
- If administrative processes by the company's human resources/benefits staff will be required, are they easy to understand and economical in terms of the amount of time they will require?
- After examining detailed information on the product, does it seem to provide what its name implies?
- Is the carrier/vendor financially stable and reputable?

If chosen properly, voluntary benefits can be a welcome, win-win supplement to an employer's benefits package.

Guidance Tells How to Maintain-or Lose Grandfathered Status Under the Patient Protection and Affordable Care Act



The Patient Protection and Affordable Care Act enacted a package of health insurance reforms for group health plans, including benefit mandates and health insurance market reforms. “Grandfathered plans” - plans in effect on March 23, 2010 (the date of enactment) are exempt from certain-but not all-of the law’s provisions.

The Internal Revenue Service, Department of Labor’s Employee Benefits Security Administration and Department of Health and Human Services have jointly issued an interim final rule regarding grandfathered plans, in particular, what changes to grandfathered plans will and will not affect a plan’s status.

Among the Act’s provisions that do not apply to grandfathered plans are the following:

- The requirement that preventive care services, including immunizations and screenings, are covered with no cost-sharing for plan participants.
- Requirements under Sec. 105(h) of the Internal Revenue Code that plan provisions do not discriminate in favor of highly compensated employees.
- Maintenance of claims and appeals processes that include external review.
- Certain benefits requirements involving provider choice, emergency services and clinical trials.

According to the interim final rule, if a grandfathered plan does any of the following, it will lose its grandfathered status:

- Eliminate all or substantially all benefits to diagnose or treat a particular condition. This includes the elimination of an element necessary to treat the condition (for example, if a plan provides counseling and prescription drugs for a mental health condition, and eliminates the counseling benefit while maintaining the prescription drug benefit, it will be considered to have eliminated substantially all benefits for the condition and lose its grandfathered status).
- Increase coinsurance rates, to any extent at all, for plan participants.
- Increase participant copayment levels by more than the greater of \$5 (adjusted annually for inflation) or a percentage equal to medical inflation plus 15 percentage points.

- Increase a fixed-dollar cost-sharing requirement other than a copayment-such as a deductible-by more than medical inflation plus 15 percentage points.
- Lower employer cost-sharing by more than 5 percentage points (for example, decreasing employer cost-sharing while increasing the percentage of employee cost-sharing from 10% to 20%).
- Add or tighten limits on what an insurer pays (for example, capping or lowering the annual dollar amount covered by a plan for specific services or adding an annual dollar limit maximum where one did not exist on March 23, 2010).
- Change insurance carriers or purchase a product from a new insurance carrier.

Plan changes such as premium increases and changes in third-party administrators will not cause a plan to lose its grandfathered status.

The interim final rule includes special provisions for insured collectively bargained plans. If the collective bargaining agreement was ratified before March 23, 2010, a fully insured plan will be considered grandfathered until the date on which the last agreement relating to the coverage in effect on that date is terminated. Self-insured collectively bargained plans are subject to the same rules as grandfathered plans that are not under a collective bargaining agreement.

As noted above, while grandfathered plans are not subject to some of the Act’s provisions, they are subject to others

As noted above, while grandfathered plans are not subject to some of the Act’s provisions, they are subject to others, such as the prohibition on lifetime limits on the dollar value of benefits and the prohibition on coverage rescissions, except in cases of fraud or an intentional misrepresentation of a material fact by an enrollee.

A grandfathered plan also is required to disclose to plan participants that, as a grandfathered plan, it may not include certain elements of the consumer protections provided for under the Act.

While grandfathered status can offer significant advantages, especially in regard to avoidance of some of the Act’s benefits mandates, employers will need to assess how these balance against the need or desire to modify plan provisions or change carriers in response to rising plan costs and rates.



Some of the smoke that flows up your chimney condenses and becomes creosote that sticks to the flue. Creosote is a hard tar-like substance that builds up over time. As the coat of creosote thickens, it increases the chance of a fire breaking out in the chimney.

When a chimney fire burns, extremely high temperatures are created that can cause cracks to form in the flue. These cracks can pose a serious health threat to your family because they allow carbon monoxide that would normally vent up the chimney to be drawn back into the home. Carbon monoxide is an odorless colorless gas that can be lethal.

To prevent chimney problems, you should have your chimney professionally inspected and cleaned yearly. The National Fire Protection Association has adopted these levels of inspection to create code NFPA 211, Standard for Chimneys, Fireplaces, Vents and Solid Fuel Burning Appliances. This is the standard that certified chimney sweeps use when cleaning chimneys:

To prevent chimney problems, you should have your chimney professionally inspected and cleaned yearly.

- Level I Inspection: Recommended when the chimney is easily accessible and the homeowner is planning to maintain it as is. In this inspection, a certified chimney sweep verifies that the chimney structure is sound and that the chimney is free of obstructions and combustible deposits such as creosote.

- Level II Inspection: If the homeowner has added a new home heating appliance or changed the type of fuel being burned, the chimney requires a Level II inspection. This inspection level may also be required after the sale of a property or an event that is likely to have caused damage to the chimney. This inspection includes the Level I inspection plus the inspection of accessible portions of the attics, crawl spaces and basements. It may also include a performance test, such as a smoke or a pressure test, and an interior chimney video inspection if recommended.
- Level III Inspection: When a Level I or Level II inspection suggests a hidden hazard and the evaluation cannot be performed without access to concealed areas, a Level III inspection is recommended. This type of inspection confirms the proper construction and condition of concealed portions of the chimney structure and the flue. Level III inspections are also necessary when investigating an incident that caused damage to a chimney or building.

In addition to yearly inspections, you may also want to consider a metal chimney liner. They protect the chimney from corrosion as a result of the byproducts released during combustion. Liners are made from stainless steel or aluminum and can be used to repair existing chimneys. They are U.L. tested, and if properly installed and maintained, they are safe and durable. Stainless steel is used in chimneys for wood burning, gas, or oil applications. Aluminum is only used for certain medium efficiency gas applications. High temperature insulation is required to be used in conjunction with the liners to ensure safety.

An Important Announcement Concerning Flexible Spending Account Reimbursements of Over the Counter (Otc) Drugs and Medications

Changes in Covered Items Effective 1/1/2011

Notwithstanding anything to the contrary contained herein, beginning 1/1/2011, health care Flexible Spending Accounts will be prohibited from reimbursing expenses for over the counter (OTC) drugs and medications unless the purchase was obtained by prescription. The documentation required for reimbursement of a

prescribed OTC drug/medicine will be subject to IRS guidelines and applicable law.

Note: This new rule will apply only to medicines and drugs. It does not apply to non-drug medical expenses (i.e. band aids, crutches, contact lens solution, etc.) A prescription would be required for items such as aspirin, cough syrup, etc.