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# Health and Welfare Plan Compliance FAQs

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# Presentation Agenda

1. MHPAEA Final Rules
2. HIPAA Reproductive Privacy Rights
3. Medicare Part D Creditable Coverage Status
4. One Big Beautiful Bill Act
5. ACA Changes to Delivery Requirements of Form 1095-C/1095-B
6. Annual Limits
7. FMLA Leave and COBRA

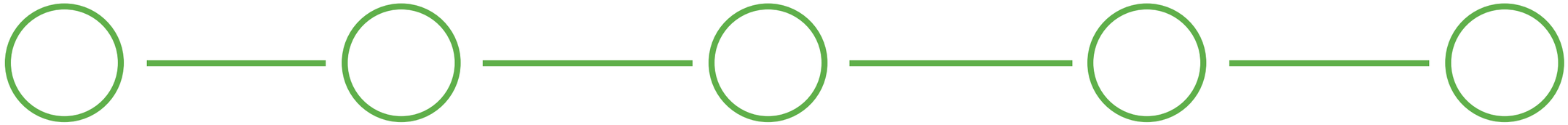
01

# What is the current status of the MHPAEA requirements after the 2024 final rules were paused?

# MHPAEA: Non-Enforcement of 2024 Final Rules

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA): BACKGROUND

### MHPAEA TIMELINE



**2008**

MHPAEA signed into law; went into effect for plan years on or after January 1, 2010

**NOVEMBER 2013**

Final rules implementing MHPAEA released; went into effect for plan years on or after July 1, 2014

**FEBRUARY 2021**

Health plans required to conduct/document NQTL comparative analyses, pursuant to the Consolidated Appropriations Act, 2021 (CAA, 2021)

**SEPTEMBER 2024**

MHPAEA Final Rules released*; Certain provisions effective January 2025 and January 2026

*Proposed Rules released July 2023

**MAY 2025**

Non-enforcement policy statement released by the Departments (DOL, HHS, Treasury) pausing enforcement of 2024 MHPAEA Final Rules

# MHPAEA: Non-Enforcement of 2024 Final Rules

## MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA): BACKGROUND

### What Does MHPAEA Require?

MHPAEA ***does not*** mandate that plans cover mental health/substance abuse (MH/SUD) benefits in the first place.

- However, MHPAEA does mandate that any MH/SUD benefits that are offered under the health plan have parity with "substantially all" of the "predominant benefits" offered under the medical/surgical (M/S) benefits of the health plan.
- Any requirements/limits imposed on MH/SUD benefits ***cannot*** be more stringent/restrictive than those imposed on M/S, including:
  - Financial Requirements (such as coinsurance, copayments)
  - Quantitative Treatment Limitations (numerical limits such as visit/treatment limits)
  - Non-Quantitative Treatment Limitations (non-numerical limits around benefit scope/duration)

# MHPAEA: Non-Enforcement of 2024 Final Rules

## What Happened?

- On May 15, 2025, the Departments (DOL, HHS, and Treasury) released a policy statement pausing their enforcement of the 2024 MHPAEA Final Rules while they reconsider them, including potentially rescinding or modifying them.
  - » Related to the lawsuit filed by the ERISA Industry Committee (ERIC) against the federal government in January 2025.

- Non-enforcement policy extends into foreseeable future: 18 months AFTER lawsuit conclusion.

- **Reminder:** 2024 MHPAEA Final Rules:
  - » Changed the way non-quantitative treatment limitation (NQTL) compliance is evaluated, and
  - » Clarified the content required to be included in written NQTL comparative analyses.

## What is a NQTL?

- Generally non-numerical requirements limiting the scope or duration of benefits.
- Examples include:
  - » Prior authorization requirements
  - » Referral requirements
  - » Formulary for Rx
  - » Provider reimbursement rates
  - » Medical necessity criteria
  - » Network composition standards
  - » Fail-first/step therapy protocols

# MHPAEA: Non-Enforcement of 2024 Final Rules

## What Does This Mean for Now?

**2024 MHPAEA Final Rules provisions that are now suspended/paused under May 2025 non-enforcement policy statement**

- **ERISA fiduciary certification**
  - » Engaging in a prudent process of selecting (and monitoring) qualified vendor(s) to perform NQTL comparative analysis
- **Meaningful benefits standard**
  - » “Meaningful” generally defined to cover at least one “core” or “primary” treatment for the condition in each prescribed classification under 2024 Final Rules
  - » Consider if coverage offered just for diagnosis is now acceptable
- **Relevant data evaluation requirements**
  - » Including network composition NQTL
- **Prohibition on use of discriminatory factors and evidentiary standards for NQTL design**

# MHPAEA: Non-Enforcement of 2024 Final Rules

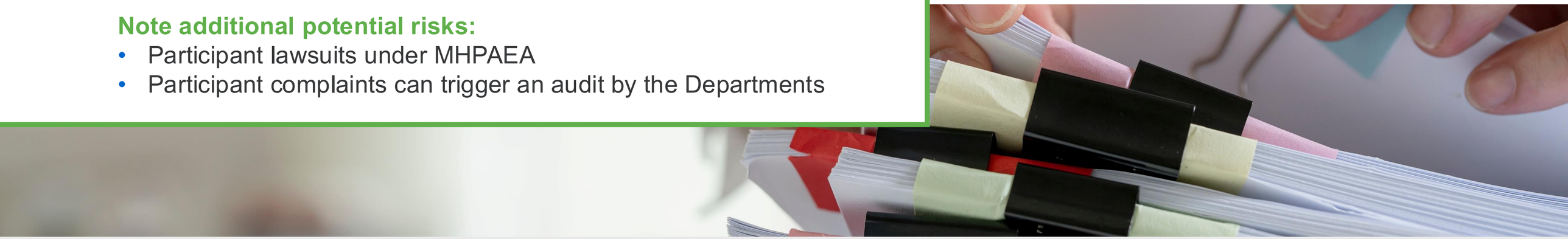
**What enforcement risks remain in effect under MHPAEA following this non-enforcement policy statement?**

**The following are all still in effect and subject to enforcement by the Departments, including potential audits:**

- MHPAEA statute
- 2013 MHPAEA Final Rules
- NQTL comparative analysis requirement under CAA, 2021
  - » May still be requested by the Departments and plan participants
  - » $110/day penalties for failure to provide to plan participant; clock starts after 30 days from request date
  - » $195/day penalties (not to exceed $1,956 per request) for failure to provide in response to DOL request
- Related sub-regulatory guidance (MHPAEA/CAA, 2021 FAQs Part 45)

**Note additional potential risks:**

- Participant lawsuits under MHPAEA
- Participant complaints can trigger an audit by the Departments



# MHPAEA: Non-Enforcement of 2024 Final Rules

## What should employers do now?

### Fully insured plan sponsors:

- Confirm NQTL comparative analysis compliance with current insurance carrier.

### Self-funded/level-funded plan sponsors:

- Determine how much support/cooperation current plan service provider(s) (TPAs/PBMs/ managed behavioral health organizations) will provide with conducting and documenting required NQTL comparative analysis.
- If already using a third-party vendor to conduct and document NQTL comparative analysis, consult with legal counsel to determine whether to continue pursuing this approach, and what the framework for the analysis will look like.
- Document all efforts.

- **Sustained MHPAEA Focus:** In the non-enforcement statement, the Departments emphasized that "MHPAEA provides critical protections for workers, individuals, and their families who need treatment for mental health conditions and substance use disorders," and the Departments "remain committed to ensuring that individuals receive protections under the law in a way that is not unduly burdensome for plans and issuers."

- **Practical Tip:** Demonstrating robust MHPAEA compliance efforts can bolster a plan sponsor's position in the event of an audit by the Departments.

02

# What does the court’s decision vacating the HIPAA Privacy Final Rule to Support Reproductive Health Care Privacy mean for plan sponsors?

# Background

## HIPAA AND THE DOBBS CASE

- The HIPAA privacy and security rules generally apply to covered entities (e.g., group health plans) and regulate the use and disclosure of an individual's protected health information (PHI).
  - Most health plans are required to have policies and procedures, business associate agreements (BAAs) with business associates, authorizations for release of PHI, and a Notice of Privacy Practices that is disclosed to plan participants.
- On June 24, 2022, the Supreme Court of the United States issued a ruling in Dobbs v. Jackson Women's Health Organization (Dobbs), which allowed states to create laws that could restrict women's access to reproductive healthcare.
  - Under these rules, certain healthcare providers felt compelled to disclose the reproductive healthcare PHI of patients to state agencies that could use the information against a patient or provider/facility assisting with reproductive healthcare needs, even if lawfully obtained.

# What is the HIPAA Final Rule on Reproductive Health Care Records?

- On April 26, 2024, the Office for Civil Rights (OCR) at the Department of Health & Human Services (HHS) published its “Final Rule to Support Reproductive Health Care Privacy.”
- The final rule adopted a “purpose-based prohibition” on the disclosure and use of reproductive healthcare-related information of covered individuals under HIPAA.
- Effective date of final rule was **June 25, 2024**.
- Covered entities were required to comply with the final rule as follows:
  - Update HIPAA policies and procedures (and BAAs, if applicable) to reflect new rules by December 23, 2024
  - Update Notice of Privacy Practices by February 16, 2026

# What is the HIPAA Final Rule on Reproductive Health Care Records?

CONTINUED

- The final rule **prohibited** a health plan and its business associates from using or disclosing PHI of a covered individual for the following purposes:
  - When conducting a criminal, civil or administrative investigation into or imposing liability on any individual that seeks, obtains, provides or facilitates lawfully-provided reproductive healthcare
  - When identifying any individual for the purpose of investigating or imposing liability on any covered entity concerning the above-listed matters

- Limited exceptions where this prohibition would not apply. For example:
  - Healthcare provider/covered entity discloses PHI to help defend itself against an investigation or other proceeding
  - Disclosure of PHI to a Statutory Inspector General for health oversight purposes

# Why was the HIPAA Final Rule on Reproductive Health Care Records vacated?

**Purl v. United States Department of Health and Human Services**

- District Court for Northern District of Texas Holding
  - The HIPAA final rule on reproductive healthcare privacy “unlawfully limits state public health laws,” potentially including the Texas law that requires child abuse reporting and public health investigations and “impermissibly redefines 'person' and 'public health' in contravention of Federal law and 'in excess of statutory authority’."
  - **This most likely means that the 2024 HIPAA Privacy Rule related to reproductive health care privacy is vacated across the country, for now.**

# Does the HIPAA Final Rule impose any requirements unrelated to Reproductive Health Care Privacy that are still effective?

- Yes, the 2024 HIPAA Final Rule also finalized the Confidentiality of Substance Use Disorder Patient Records rule issued in February 2024
- Plan sponsors are required to amend their Notice of Privacy Practices by February 16, 2026, to reflect the protection of substance use disorder information.
  - » Currently monitoring whether HHS will provide sample language/notice

# What does this case mean for plan sponsors?

- Covered entities and related business associates will no longer be subject to the reproductive healthcare privacy requirements of the HIPAA Final Rule, including requirements for updated policies, training, amendments to business associate agreements (if applicable), and attestation forms related to the protection of reproductive healthcare records.
  - If plan sponsors amended their policies and procedures and NPPs to reflect the HIPAA Final Rule related to reproductive healthcare privacy, they may want to amend these documents to remove those references in order to avoid violating state laws such as those referenced in the Purl case.

- While the Court vacated the parts of the HIPAA Final Rule related to reproductive healthcare privacy, the provisions relating to preserving confidentiality of records for **substance use disorders remain in effect**.
  - **Plan sponsors still need to amend their Notice of Privacy Practices related to substance use disorder information by February 16, 2026**.

- Covered entities such as group health plans remain subject to the remaining HIPAA Privacy Rules, applicable state laws, and local rules that may provide additional privacy protections for reproductive health information and other PHI. Covered entities should consult with their legal counsel to determine the impacts of this decision on their privacy obligations.

03

# What is the current status of the Medicare Part D Creditable Coverage rules?

# Medicare Part D

## BACKGROUND INFORMATION

### Inflation Reduction Act

Inflation Reduction Act (IRA) - Changes to Medicare Part D effective January 1, 2025:

- Annual deductible increase - $590 (vs. $545 in 2024)
- Change from 4 coverage stages to 3 – coverage gap eliminated
- New out-of-pocket maximum ($2,100 in 2026 vs. $8,000 in 2024)
- Eliminated beneficiary coinsurance in catastrophic phase and established manufacturer’s discount program

### Impact on Group Health Plans

These updated parameters will increase the actuarial value of Medicare Part D prescription drug coverage used to determine whether a group health plan’s prescription drug benefits are "creditable" for 2025 and into the future

- “Creditable" coverage must provide an actuarial value that is at least equivalent to Part D coverage
- Will be applied to Retiree Drug Subsidy program actuarial value, Part D beneficiary notices, and CMS annual disclosure

### Impact to Retiree Drug Subsidy Programs

Sponsors of retiree drug benefit plans may also need to update their plan designs to comply with the minimum standards

# Determining Creditable Coverage Status

## BACKGROUND INFORMATION

### Different Methods for Determining Whether the GHP is Creditable vs. Non-Creditable

Guidance includes three methods for determining whether a group health plan's drug benefits are creditable:

1. Actuarial Determination method (required for plans receiving Retiree Drug Subsidy (RDS) payments from CMS)

2. Simplified Determination method (slightly different rules for integrated vs. non-integrated medical/Rx coverage); or

3. **Revised Simplified Determination method – Available as of January 2026**

# Simplified Determination Method

The 2009 (current) Simplified Determination method guidance includes two categories for determining whether a group health plan's drug benefits are creditable, depending on whether the plan is considered an Integrated or Non-Integrated Plan:

### Integrated Plans

An integrated plan is any plan of benefits that is offered to a Medicare eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

1) A combined plan year deductible for all benefits under the plan;
2) A combined annual benefit maximum for all benefits under the plan; and
3) A combined lifetime benefit maximum for all benefits under the plan.

### Non-integrated Plans

Apply non-integrated test for creditable coverage simplified determination if plan does not meet definition of integrated plan.

Can a plan with NO lifetime maximum be treated as integrated for purposes of simplified determination method?

# Simplified Determination Method

| | INTEGRATED PLANS | NON-INTEGRATED PLANS |
|---|---|---|
| (1) | Coverage for brand and generic Rx | Coverage for brand and generic Rx |
| (2) | Reasonable access to retail providers | Reasonable access to retail providers |
| (3) | Designed to pay on average at least 60% of participants' Rx expenses | Designed to pay on average at least 60% of participants' Rx expenses |
| (4) | Plan has:<br>• Combined medical/Rx plan year deductible for all benefits under the plan, not to exceed $250<br>• No annual benefit maximum, or a combined medical/Rx maximum annual benefit of at least $25,000, and<br>• No less than a $1 million lifetime combined medical/Rx benefit maximum | Satisfies at least one of the following:<br>(a) No annual benefit maximum, or<br>(b) Plan has an actuarial expectation that the amount payable by the plan will be at least $2,000 per Medicare-eligible beneficiary |

# *Revised* Simplified Determination Method

| | REVISED SIMPLIFIED DETERMINATION METHOD |
|---|---|
| (1) | Provides reasonable coverage for brand name and generic prescription drugs **and biological products** |
| (2) | Provides reasonable access to retail pharmacies; and |
| (3) | Designed to pay on average at least 72% of participants' Rx expenses |

# Determining Creditable Coverage Status

## Application of the Simplified Determination Method and the Revised Simplified Determination Method

### Simplified Determination Method

The **current** Simplified Determination method may only be utilized for plan years beginning in **calendar year 2025 and in 2026** (pending future guidance on whether the current Simplified Determination Method could continue to be utilized by plan sponsors in later calendar years).

### Revised Simplified Determination Method

The Revised Simplified Determination method may be used for all plan years beginning in **calendar year 2026 (i.e., beginning January 1, 2026)** and going forward under guidance issued as of April 2025.

04

# How does the One Big Beautiful Bill Act impact employee benefits?

# One Big Beautiful Bill Act

On May 18, 2025, the House Budget Committee advanced the 2025 Federal Budget Reconciliation Bill (H.R. 1 - One Big Beautiful Bill Act) proposing changes to a variety of health-related provisions.

On May 22, 2025, the U.S. House of Representatives passes the 2025 Federal Budget Reconciliation Bill by a vote of **215** in favor and **214** opposed.

On July 1, 2025, the U.S. Senate passed an amended version of the 2025 Federal Budget Reconciliation Bill by a vote of **51** in favor and **50** opposed. Several provisions did not make it into this version.

On July 3, 2025, the U.S. House of Representatives passed the Senate's amended version without additional changes by a vote of **218** in favor and **214** opposed.

On **July 4, 2025**, the President signed the 2025 One Big Beautiful Bill Act into law. The Act covers a variety of topics such as health, tax, education, and energy.

# What are the telemedicine and HSA final impacts?

- The OBBBA reinstated and made permanent the COVID-era relief permitting individuals enrolled in an HDHP (or stand-alone telehealth coverage) that provides non-preventive telemedicine or other remote care services for less than fair market value cost (such as $0 copay) to maintain eligibility to contribute to an HSA.
- Retroactive application to January 1, 2025.
- Employers may reinstate $0 copay or below fair market value (FMV) copay for telemedicine benefits/services.
- Telemedicine benefits appear to not be limited to primary care/urgent care visits.
- Further guidance from the agencies would be helpful.

# How are direct primary care arrangements and HSAs impacted?

- Under the OBBBA, coverage under a direct primary care service arrangement (DPC) does not disqualify an individual from HSA eligibility (assuming they are otherwise HSA-eligible), beginning on or after **January 1, 2026**.
- The monthly membership fee must be no more than **$150** self-only/**$300** family coverage.
- **Direct primary care service arrangement** means an arrangement under which an **individual** is provided medical care consisting solely of primary care services provided by **primary care practitioners** if the sole compensation for such care is a **fixed periodic fee**.
- Certain services specifically excluded from **primary care services** include:
  - Procedures that require the use of general anesthesia;
  - Prescription drugs (other than vaccines); and
  - Laboratory services not typically administered in an ambulatory primary care setting.
- Individuals may use HSA funds to pay for the DPC fee.
- Further guidance from the agencies is expected.
- **NOTE:** This provision does **not** change prior guidance addressing on-site/near-site clinics and HSA contribution eligibility. An on-site clinic could qualify as a DPC, depending on the structure/arrangement.

# Did the dependent care FSA limit increase?

- The OBBBA increased the tax exclusion for dependent care assistance plan (DCAP) benefits for the first time in nearly 40 years.
- Effective for plan years beginning on or after **January 1, 2026**, single individuals and married couples filing jointly may exclude from income up to $7,500 a year for dependent care benefits and $3,750 for married individuals filing separately.
- DCAP Limit History
  - 1986 - 2025 - $5,000
  - 2026 - $7,500
  - Future years - $7,500 unless Congress amends the statute again
- No changes to qualified dependent care expenses.
- No annual adjustment for inflation.
- No changes to 55% average benefits test. Employers may consider testing early and in the middle of the plan year to address any nondiscrimination issues with the increase in the limit on nontaxable dependent care benefits.
- Employers adopting the increased contribution limit should consult with their DCAP/DCFSA vendor to update plan materials and employee communications.

# What changes were made to education assistance programs?

- The OBBBA permanently extends the ability of employers to reimburse/pay for an employee's student loans on a tax-free basis through an IRC Section 127 educational assistance program.
- This was previously allowed under the CARES Act and extended under the CAA, but was set to expire on December 31, 2025.
- Under these programs, an employer may reimburse or pay principal and interest on employees' student loans on a non-taxable basis.
- Beginning on January 1, 2026, the student loan provision will be permanent.
- The non-taxable limit for 2025 and 2026 is $5,250.
- The limit will have an annual inflation adjustment beginning with tax years after December 31, 2026.
- Employers wishing to implement this change should amend plan documents, as needed, and coordinate with their educational assistance program vendor.

05

# What changes were made to the delivery rules for the ACA Forms 1095-C/1095-B?

# Employer Reporting Improvement Act

## Date of Birth can be a Substitute for a Dependent's Taxpayer Identification Number

The Act (effective January 1, 2025) permits employers to use an individual's date of birth instead of their Taxpayer Identification Number (TIN) on Forms 1095-B and 1095-C when the TIN is not available

- Employer must request TIN at least 3 times

## Letter 226-J Extension of Response Time and Six Year Statute of Limitations

The Act also provides ALEs an expanded timeframe to respond to IRS letters of potential Employer Mandate violations (i.e., Letter 226-J). ALEs will now have a minimum of 90 days from the date of the IRS' initial letter to respond, compared to the previous 30 days from the date of the initial IRS letter.

Further, under these same rules, the IRS has six years to assess Section 4980H employer shared responsibility penalties against an ALE. The six-year period will begin with an ALE's due date for filing Forms 1094-B or 1094-C or from the date an ALE filed these forms, whichever is later.

# Paperwork Burden Reduction Act

## Simplification of the Furnishing Requirement to Full-Time Employees

- Employers may now meet their Form 1095-C delivery obligations to full-time employees by posting a message on the employer's website that notifies full-time employees of their ability to request their Form 1095-C from the employer. This aligns Form 1095-C with 1095-B delivery requirements and relieves an employer from having to furnish a copy of Form 1095-C to every full-time employee, limiting delivery of paper copies to only those who request it.
  - » In lieu of automatically sending a Form 1095-C to all full-time employees, employers may post a "clear, conspicuous, and accessible notice" on their public website that an individual may request a paper copy of the Form 1095-C at any time.
  - » Posting must be completed on or before the annual deadline for furnishing Form 1095-C (e.g., March 2, 2026, for the 2025 reporting year) and remain posted in the same location until October 15 of that year (i.e., the year following the year reported).
  - » The 1095-C must be delivered to the requesting employee by January 31st of the year following the applicable reporting year, or within 30 days of the request, whichever is later.

## States May have Different Reporting Rules

- Employers in jurisdictions that have their own individual mandate and reporting requirements that allow plan sponsors to use Forms 1095 and 1094 to meet these requirements (e.g., California, Massachusetts, New Jersey, Rhode Island, and Washington, DC) should consult with legal counsel to determine whether electronic delivery of Forms 1095-B and 1095-C and TIN replacement applies for state purposes.

# Paperwork Burden Reduction Act

## Furnishing 1095-C to Full-Time Employees upon Request under the Simplified Rule

- If an individual makes a request to receive the 1095-C, a paper form must be delivered to them, unless the individual has affirmatively consented to electronic delivery of the Form 1095-C.
- Consent for Electronic Delivery of a Form 1095-C must reference the specific form or forms that the consent applies to and include:
  - A statement that a paper copy will be sent if the employee does not consent, how to revoke the consent for future statements, and how to request a paper copy;
  - The duration of the consent, including whether the consent applies to all future statements or just the statement being requested, and when electronic statements will no longer be delivered (for example, after employment ends);
  - How to update the employee's contact information, a notice of any hardware or software needed to access the statement and when access will expire, if applicable; and
  - Notice that the electronic statement may need to be printed and attached to a federal, state, or local income tax return.

06

# What are the various annual limits for 2026?

# 2026 Limits – HDHP – HSA – ACA

| | 2025 | 2026 |
|---|---|---|
| **HSA Contributions** | | |
| • Self-Only | $4,300 | $4,400 |
| • Family | $8,550 | $8,750 |
| • Catch-Up (Age 55+) | $1,000 | $1,000 |
| **HDHP Minimum Annual Deductible** | | |
| • Self-Only | $1,650 | $1,700 |
| • Family | $3,300 | $3,400 |
| **HDHP Out-of-Pocket Maximum** | | |
| • Self-Only | $8,300 | $8,500 |
| • Family | $16,600 | $17,000 |
| **ACA Out-of-Pocket Maximum** | | |
| • Self-Only | $9,200 | $10,600 |
| • Family | $18,400 | $21,200 |

# 2026 Limits – FSA & Commuter Benefits

| Benefit | 2025 | 2026 |
|---|---|---|
| **FSA** (general purpose and limited purpose FSA) | $3,300 | $3,400 |
| **FSA Carryover** | $660 | $680 |
| **Dependent Care FSA** | $5,000/$2,500 for married filing separately | $7,500/$3,750 for married filing separately |
| **Commuter Benefits**<br>• Qualified Transportation Expenses<br>• Qualified Parking Expenses | <br>$325/month<br>$325/month | <br>$340/month<br>$340/month |

06

# How do FMLA leave and COBRA interact?

# How does COBRA apply to FMLA leave?

**COBRA continuation rights apply at the end of FMLA leave**

- Although taking FMLA may result in a reduction of hours, beginning FMLA leave is not a qualifying event under the COBRA rules.
- However, failing to return to work from FMLA leave may be a qualifying event under the COBRA rules.
  - » Even if the employee does not elect to continue group health plan coverage during FMLA leave
  - » Even if the employee elects to continue group health plan coverage during FMLA leave but fails to pay the premium for that coverage during FMLA leave
- When FMLA leave begins/ends is determined under the FMLA not COBRA.
- The COBRA maximum coverage period generally begins on the last day of FMLA leave (date of the qualifying event).

# When will a COBRA Qualifying Event occur under FMLA?

**A COBRA qualifying event will occur if the following three circumstances exist:**

- The employee, spouse, or dependent child is covered by an employer's group health plan on the day before the first day of FMLA leave (or becomes covered during the FMLA leave);
- The employee does not return to employment at the end of the FMLA leave; and
- The individual (employee, spouse, or dependent child) would otherwise lose the employer-provided group health plan coverage before the COBRA maximum period (typically 18 months) if COBRA was not offered/available.

# What if an employee takes paid leave during FMLA leave?

**Using Paid Leave During FMLA Leave:**

- Under specific requirements, an employee may choose (or the employer may require the employee) to use accumulated paid leave to cover some or all of the employee's FMLA leave time.
  - » Examples include: paid sick leave, PTO, compensated short-term disability insurance, or compensated long-term disability insurance.
- The effects on COBRA eligibility for FMLA-protected short-term or long-term disability absences are identical to those for unpaid FMLA time off.
- Note that paid short-term or long-term disability leave might not be leave under the FMLA, especially when an employer does not have at least 50 employees.

# What if an employee takes non-FMLA leave after FMLA leave?

**What happens will typically depend on the employer's governing plan documents and leave policies:**

- The end of FMLA leave by itself is not a COBRA triggering event
  - An employee may be entitled (based on the employer's leave policies) to continue on non-protected/non-FMLA leave once their FMLA leave is exhausted
  - Whether COBRA is triggered once the employee switches to non-protected/non-FMLA leave will depend on if benefits continue during that non-protected/non-FMLA leave, which is based on the employer's plan documents and/or leave policies

# What if an employee takes non-FMLA leave after FMLA leave?

CONTINUED

### Example: Employer Policy Offers Benefits During Unprotected Leave

- An employer may have language in their plan documents and/or leave policies that allows benefits to continue during a non-FMLA, unprotected leave that follows FMLA leave.
  - The ability of benefits to continue during unprotected leave should be detailed in the employer's plan documents and/or leave policies (as well as ways premiums can be paid during the leave of absence).
  - The employer should confirm the carrier/stop-loss provider permits the coverage to continue during such unprotected leave (e.g., carrier may allow benefits to continue during unprotected leave for six months).
- Assuming the employee continues to pay the applicable premium during the unprotected leave, and the employee does not return to work once the unprotected leave is exhausted, COBRA coverage would be offered at the time the employee loses coverage (e.g., due to loss of eligibility for coverage or due to termination of employment).
- Applicable Large Employers using the Look Back Measurement Method should verify whether the employee is in a stability period when they begin an unprotected leave of absence, as this may affect the obligation to continue to offer coverage.

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