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international group program

IGP Country Profile 2022

United States

Prepared by:
Prudential Insurance Company of America

Preface

This Country Profile has been prepared by **The Prudential Insurance Company of America** for the International Group Program (IGP).

The United States Country profile represents an overview of legal, regulatory and market conditions that may change. It neither represents, nor should it be relied upon for tax or legal advice.

The International Group Program (IGP) is a network of major life insurance companies (Network Partners) operating throughout the world, who work together to meet the group insurance and pension needs of international corporations and their affiliates, branches, and subsidiaries.

Since 1967, the International Group Program has been an industry leader in the field of international benefits management, serving more multinational companies than any other network. IGP is represented in approximately 70 countries throughout the world and is known for the flexibility and quality of service we provide to our clients.

Working closely with our headquarters' staff in Boston, our regional offices in Brussels, Singapore and Tokyo, as well as our Regional Coordinator in Mexico, IGP Network Partners offer corporate clients the advantages of experienced local insurance management coupled with the resources of a professionally trained staff that specializes in international employee benefits.

IGP is part of John Hancock Life Insurance Company (U.S.A.), the U.S. operation of Manulife Financial Corporation, a leading financial services group based in Toronto, Canada. Manulife offers its clients a diverse range of financial protection products and wealth management services. Both Manulife Financial and John Hancock are internationally recognized brands that have stood for financial strength and integrity for more than a century.

The information contained in the IGP Country Profiles is considered proprietary and any material extracted from a profile must be attributed to IGP.

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Your Local Link to IGP in the United States: The Prudential Insurance Company of America

The Prudential Insurance Company of America

The IGP Network Partner in the United States

Prudential Financial, Inc. (NYSE: PRU), a financial services leader with more than USD 1.727 trillion of assets under management as of December 31, 2021, has operations in the United States, Asia, Europe, and Latin America.

Prudential's diverse and talented employees are committed to helping individual and institutional customers grow and protect their wealth through a variety of products and services, including life insurance, annuities, retirement-related services, mutual funds and investment management. In the US, Prudential's iconic Rock symbol has stood for strength, stability, expertise and innovation for more than a century. For more information, please visit https://www.investor.prudential.com/home/default.aspx.com.

Our Group Insurance segment manufactures and distributes a full range of group life, long-term and short-term group disability, and group corporate, bank and trust-owned life insurance in the US primarily to institutional clients for use in connection with employee and membership benefits plans.

Group Insurance also sells accidental death and dismemberment, other ancillary coverages, and provides plan administrative services in connection with its insurance coverages. We are one of the leading providers of group insurance in the United States. Our resources, financial strength and stability allow us to honor long-term commitments to employers and employees alike.

Prudential is located on the internet at: http://www.prudential.com.

Key Products

Life

- Basic, Optional & Dependent Term Life
- Group Universal Life and Group Variable Universal Life
- Basic and Optional Accidental Death & Dismemberment
- Business Travel Accident

Disability

- Short-Term Disability
- Long-Term Disability
- Integrated Short & Long-Term Disability
- Disability & Absence Management Solutions

Voluntary Benefits

- Critical Illness
- Accident
- Hospital Indemnity

Pensions

- Managed Funds
- Pension Risk Transfer

Other

- Captive Reinsurance
- Multinational Pooling
- Retiree Benefit Funding and Buyout Solutions

Group Insurance coverages are issued by The Prudential Insurance Company of America, and Group Variable Universal Life insurance is distributed through Prudential Investment Management Services LLC (“PIMS”). Both are Prudential Financial companies, Newark, NJ.

Social Security Benefits and Customary Private Employee Benefits

Introduction:

All employees and self-employed persons are eligible for Social Security in the United States. Special systems exist for government workers. Old-age, death and disability benefits are payable if service and age requirements are met.

Social Security Contributions:

Contributions are calculated as a percentage of a base number, and employers and employees contribute equally. The 2022 Social Security Contribution Base (SSCB) for old age, death and disability benefits is USD 147,000 and contribution rates for employers and employees are 6.20%. The health contribution rate is 1.45% each. High income employees pay an additional 0.9%.

Rates of Contribution as % of SSCB:

2014 - 2022	EMPLOYER	EMPLOYEE	TOTAL CONTRIBUTION
OLD AGE, DEATH & DISABILITY	6.20%	6.20%	12.40%
MEDICARE	1.45%	1.45% * High income employees pay an additional 0.9% Medicare tax.	2.9%

NOTE: Effective January 1994, as a result of the Omnibus Reconciliation Act of 1993, the earnings limit for Medicare was eliminated.

Insured Status:

Insured Status is based on “quarters of coverage”.

Four quarters of coverage are earned in each year in which the worker earns a minimum amount (2022 = USD 6,040); lower earnings yield proportionately fewer quarters.

Fully Insured Status gives eligibility for all benefits except disability benefits, which also require Disability Insured status. The maximum number of quarters of coverage which will ever be required is 40.

A fully insured person is one, who at or after attainment of age 62, or at death or disability if earlier, has at least six quarters of coverage and has at least one quarter of coverage (acquired at any time) for every year elapsed after 1950 (or year of attainment of age 21 if later) and before the year of attainment of age 62 (or year of death or disability if earlier).

Currently Insured Status alone (i.e., without being fully insured) provides eligibility only for certain survivor benefits.

Currently, insured status requires six quarters of coverage within the 13-quarter period ending with the quarter of death or entitlement to old-age benefits.

Disability Insured Status Social Security work credits are based on total yearly wages or self-employment income. A worker can earn up to four credits each year. The amount needed for a credit changes from year to year. In 2022, for example, a worker earns one credit for each USD 1,510 of wages or self-employment income.

When a worker earns USD 6,040, he or she has earned four credits for the year. The number of work credits needed to qualify for disability benefits depends on a worker's age when he or she becomes disabled. Generally, a worker needs 40 credits, 20 of which were earned in the last 10 years ending with the year he or she becomes disabled. Younger workers may qualify with fewer credits.

Social Security Benefits and Customary Private Employee Benefits

RETIREMENT BENEFITS	
Social Security Benefits	**Customary Private Employee Benefits**
Benefits The maximum monthly benefit for a person retiring in 2022 at full retirement age is USD 3,240 (vs. USD 3,113 in 2021. *Working after Benefits Begin* In 2022, if an employee is under the Normal Retirement Age (NRA) (66 + 10 months) for the whole year, he or she can earn USD 19,560 (in 2022) without losing any benefits. For recipients under the NRA, the reduction is USD 1 of each USD 2 of earnings. If an employee attains NRA in 2022, he or she can earn USD 51,960 in the period before the month he or she attains NRA without a reduction in benefits. If earnings exceed this, then USD 1 in benefits is withheld for every USD 3 earned above the USD 51,960. There is no reduction after NRA regardless of income. **Note:** In the first year of eligibility only, a monthly test also applies if it will give the recipient better results than the above described benefit. In the first year, a benefit can be received for any month in which the recipient earned 1/12 of the earnings limit or less. If more than 1/12 of the annual limit is earned, then no benefits are payable for that month unless they are already payable using the previously described method. A worker's pension is increased by a range of 5.5 to 8% for each year that he or she delays retirement past NRA up to age 70 depending upon the year of birth. Benefits paid to dependents or survivors are not affected. *Dependent Supplement* An additional 50% of the worker's pension is payable to each eligible dependent, subject to the Maximum Family Benefit. Dependents include unmarried children under age 18 (age 19 if full time high school students), an unmarried child who became disabled before reaching age 22 (and has remained so since) and a dependent spouse. The 50% supplement is payable to a dependent spouse at any age if he/she is caring for one or more dependent children or at NRA if there are no dependent children. A dependent spouse with no dependent children may receive a reduced benefit before NRA. If the spouse is entitled to a retirement pension, the supplement is reduced by the amount of that pension.	**Benefits** Presently, nearly 710,000 qualified defined benefit and defined contribution plans are in force in the United States. Over the past several years, almost all new plan formations have been defined contribution, so now defined contribution assets exceed defined benefit assets. • A **defined benefit** (DB) pension plan is an arrangement in which the employee accrues a benefit payable in the form of an annuity at the employee's normal retirement date. The benefit may be a percentage of career/final average salary or a flat dollar amount and may also be related to years of service. Under defined benefit pension plans, certain vested accrued benefits are guaranteed by a governmental agency, the Pension Benefit Guaranty Corporation (PBGC). The PBGC's maximum guaranteed benefit for a single life annuity for 2022 is USD 74,454 annually at age 65. This federal insurance program is funded by plan sponsors (employers) through premiums paid on a per participant basis plus additional premiums based on the adequacy of plan funding. In addition, minimum yearly employer contribution requirements apply to defined benefit plans, which are prescribed and monitored by the government with the intent of minimizing the under-funding of these plans. • A **cash balance** plan is a type of defined benefit plan in which the employee accrues a benefit in the form of a hypothetical account balance. An employee's account balance is credited with employer allocations and investment earnings determined under a formula selected by the employer and stated in the plan. These plans are considered defined benefit arrangements because (a) the allocation and the guaranteed credits are fixed by the plan's formula, and (b) investment gains or losses accrue to the plan, not the participant. • A **defined contribution** (DC) plan provides for the deposit of contributions made by the employee, employer, or both in individual accounts for employees. An employee's benefit is equal to the value of the individual account, which will vary based on investment income, gains and losses, expenses, employer contributions and any employer forfeitures on account of other participants (non-vested portions) that may be reallocated to active participants. 401(k) plans, named for the corresponding section of the Internal Revenue Code, have become the most popular form of defined contribution plan in the US. Participants in a 401(k) plan elect to contribute a percentage of their own salary to a plan generally on a pre-tax basis (401(k) plans also are known as "cash or deferred arrangements" for this reason). Alternatively, some plans automatically enroll employees at a set percentage that they may opt out of or

	change. The employer typically matches some portion of the employee's contribution; for example, a 50% match on the first 6% of the compensation an employee contributes is a common formula.
Cost-of-Living Adjustments (COLA) All pensions are automatically adjusted (upward only) as of January of each year based on the third quarter of the current year versus the prior year. The most recent cost-of-living increase in benefits, payable as of January 2022, was 5.9%. In 2021, the cost-of-living adjustment was 1.3%. Effective after 1984, a stabilizer to limit COLA increases was built into the program. For any year that the reserves of the combined Old Age, Survivors Insurance (OASI) and Disability Insurance (DI) trust funds drop below a certain percentage of expected benefit payments for the year, then the COLA for that year would be based on the lower of the increase in the consumer price index (CPI) or the average wage index.	
Eligibility All employees and self-employed persons are eligible. Special systems exist for railroad employees, federal government employees, and many employees of state and local governments. The normal retirement age in the United States is age 65 for those born before 1938. For those born in 1938 through 1960, NRA increases from age 65 to age 67 on a graduated basis. For those born in 1958, NRA rose to 66 + 8 months in 2022. For those born in 1959, NRA rose to 66 + 10 months in 2022 (with a reduction in benefits for retirement at age 62 – 65 + 10 months). NRA is 67 for those born in 1960 or later. Computing a Social Security benefit is very complicated, requiring detailed information about the worker's age, date of retirement, disability or death, and a year-by-year earnings history. For fully insured status (please see previous section; Insured Status).	Eligibility DB and Cash Plans: Generally, a plan may require a person to reach age 21 to be eligible to participate in the plan and to have a year of service. The IRS requires employers to allow employees to be able to join a DC plan if they are 21 years old and have a year of service completed.

Customary Private Employee Benefits Additional Information:

The federal government has played a key role in the development of private pension and profit-sharing plans since the 1920's, but it was not until 1974 that comprehensive regulation of private plans came into existence with the passage of the "Employee Retirement Income Security Act of 1974" ("ERISA").

ERISA imposes numerous and significant requirements on employer-sponsored benefit plans, including those that provide retirement, health and other types of welfare benefits. As a rule, private employers don't have to offer employees any of the benefits subject to ERISA, but to the extent they do, they must comply with ERISA's terms. ERISA generally preempts state law relating to employee benefit plans, although ERISA preemption does not apply to insurance policies (as opposed to self-funded benefit plans).

Retirement Benefit Plans:

In addition to ERISA requirements, Section 401 of the Internal Revenue Code, as amended, sets forth numerous requirements that plans must meet to be tax-qualified plans to which special tax advantages are available. A plan must be established by the employer for the exclusive benefit of employees and their beneficiaries, assets of the plan must be maintained under a trust agreement or an insurance company group annuity contract, and the plan must be a definite, funded and written program that is communicated to employees.

Plans must satisfy requirements related to employee eligibility, vesting of contributions, in-service withdrawal restrictions, distributions, spousal protections, participant notifications, funding levels (defined benefit plans), and must not discriminate in favor of highly compensated employees.

Financial Accounting Standards Applying to Post-Retirement and Other Post - Employment Benefits

Private sector employers preparing financial statements under US Generally Accepted Accounting Principles must account for pensions, retiree medical, retiree life insurance and any other post-retirement benefits on an accrual basis that recognizes the cost over the service period of the participants, rather than on a cash basis or other basis. In addition, employers must account for most post-employment benefits (such as long-term disability benefits) on an accrual basis.

These employers must recognize on their balance sheets the net funded status of the post-retirement and other post-employment benefit plans that they sponsor, even if the plan is unfunded. For multi-employer plans (plans providing collectively bargained benefits to employees of more than one employer), employers do not recognize the net funded status on the balance sheet or determine an expense on an accrual basis, but just disclose the cash paid to the organization sponsoring the plan.

Retiree health and other non-pension post-employment benefits offered by state and local government employers are subject to rules of the Governmental Accounting Standards Board (GASB). GASB has recently changed its financial accounting and reporting standards to require governmental employers to report net liabilities and costs under a different approach than that required for private-sector employers.

Retirement Legislative Developments (As of April 2022)

Department of Labor Fiduciary Rule

The Department of Labor (DOL)'s 2016 investment advice fiduciary rule was invalidated as regulatory overreach by the US 5th Circuit Court of Appeals in 2018. The court's decision effectively reinstated the DOL's original 1975 investment advice fiduciary rule.

The 1975 rule defines an investment advice fiduciary more narrowly than the nullified 2016 rule to include a person who (i) renders advice or makes recommendations as to the advisability of investing in, purchasing, or selling securities or other property; (ii) on a regular basis; (iii) pursuant to a mutual agreement between the individual and the plan — and the advice (iv) serves as a primary basis for investment decisions with respect to plan assets, and (v) is individualized to the particular needs of the plan.

On June 30, 2020, the Securities and Exchange Commission's (SEC) four 'Regulation Best Interest rules' which are designed to create a unified conflict of interest mitigation standard for all brokers and advisers, not just those working under ERISA took effect. This was preceded by a proposal on June 29, 2020, from the Trump Administration's DOL to replace the defunct 2016 fiduciary rule and allow for exceptions under ERISA

to investment advice fiduciaries, provided they act in the best interests of retirement savers. The proposal is intended to align with the SEC's rules. In a move that took many by surprise, President Biden's DOL allowed the previous administration's directive to become effective in February 2021. However, it is expected that the DOL will continue to build on the rule by adding additional guidance and redefining what is meant by 'fiduciary advice'.

SECURE Act 2.0

The SECURE Act represents retirement security legislation that became law on December 20, 2019. Highlights include allowing long-term part-time workers to participate in 401(k) plans and requiring employers maintaining a 401(k) to have a dual eligibility requirement under which an employee must complete either one year of service (with the 1,000-hour rule) or three consecutive years of service where the employee completes at least 500 hours of service.

The new “Secure 2.0” - securing a strong Retirement act (H.R.2954) was passed by the house on March 29, 2022, with bi-partisan support. The measure is intended to build upon the original Secure Act of 2019, which ushered in changes aimed at increasing retirement security. The key differences in some provisions that could directly affect retirement savers or retirees includes:

- **Auto-enrollment** in 401(k) plans: The bill that cleared the House would require employers to automatically enroll employees in their 401(k) plan at a rate of at least 3% and then increase it each year until the worker is contributing 10% of their pay. Businesses with 10 or fewer employees and new companies in business for less than three years are among those that would be excluded from the mandate.

- **Catch-up contribution**: Under current law, retirement savers age 50 or older can make so-called catch-up contributions to their retirement savings. On top of the standard annual contribution limits — $20,500 for 401(k) plans and $6,000 for individual retirement accounts in 2022 — those who qualify can put an extra $6,500 in their 401(k) or $1,000 in their IRA. Both the House and Senate bills aim to expand those amounts, although the specifics differ. The House bill would expand the 401(k) catch-up to $10,000 for individuals who are age 62, 63 or 64 beginning in 2024. Workers enrolled in so-called SIMPLE plans would be allowed $5,000 in catch-up contributions, up from the current $3,000.

- **Required minimum distributions**: The 2019 Secure Act changed when required minimum distributions, or RMDs, from retirement accounts must begin to age 72, from 70½. Under the House-passed bill, those mandated annual withdrawals wouldn’t have to start until age 73 in 2023, and then age 74 in 2030 and age 75 in 2033.

  The Senate proposal would raise the RMD age to 75 by 2032. It also would waive RMDs for individuals with less than $100,000 in aggregate retirement savings, as well as reduce the penalty for failing to take RMDs to 25% from the current 50%.

- **Annuities**: To receive an income stream later in life is a qualified longevity annuity contract, or QLAC. Once an annuity is purchased, an individual must specify when they would want the income to start. However, the maximum that can go into a QLAC is either $135,000 or 25% of the value of your retirement accounts, whichever is less.

  Both bills would remove the 25% cap. The Senate measure would also increase the maximum amount allowed in a QLAC to $200,000.

Contrasting fortunes of the PBGC's single-employer and multiemployer programs

The Pension Benefit Guaranty Corporation (PBGC)'s single-employer and multiemployer programs continue to reflect contrasting financial positions. The single-employer insurance program reported a favorable net position of $30.9 billion at the end of the 2021 fiscal year, primarily credited to increased premium collections and investment income.

By comparison, the multiemployer program continues to struggle despite reporting a slight improvement in 2021 with a reported deficit of $57 billion ($63.7 billion in 2020). According to the DOL, the multiemployer program remains severely underfunded and is on track to become insolvent by the end of 2026 if action is not taken to repair the program. According to the agency's annual projections report, the program currently covers approximately 10.9 million participants in an estimated 1360 multiemployer plans. The report stresses that without legislative changes, the large deficits reported by the multiemployer program are expected to increase over time.

There has already been some movement towards shoring up the multiemployer program, including the enactment of the Butch Lewis Emergency Pension Plan Relief Act of 2021 (S.547), which was signed into law by President Biden on March 11, 2021, as part of the American Rescue Plan Act of 2021 (H.R.1319). While this law provides financial assistance to eligible multiemployer plans at risk of becoming insolvent, it does not address any structural reforms needed in the PBGC multiemployer program. Instead, the bill provides financial aid by allocating money from the Treasury Department via the PBGC to struggling multiemployer plans.

Rollback of COVID relief packages

Retirement relief measures introduced as part of the CARES Act were largely discontinued at the end of 2020. This Act was introduced to address the economic impacts of the COVID-19 outbreak. It included changes to both defined benefit and defined contribution plans, including allowing employers with defined benefit plans to delay contributions due in 2020 until January 1, 2021, and suspending the RMD rule for 2020.

The American Rescue Plan Act of 2021 ("ARPA") (H.R.1319), which was signed into law in March 2021, contains the Butch Lewis Emergency Pension Relief Act aimed at providing financial relief to struggling multiemployer and single-employer plans. In addition, Congress passed the COVID-Related Tax Relief Act of 2020 (COVIDTRA), which was enacted as part of the Consolidated Appropriations Act of 2021 by President Trump in December 2020. COVIDTRA includes legislation to repackage the Coronavirus Related Distribution (CRD) exception allowed during 2020 as a Qualified Disaster Distribution. Similar to a CRD, distributions not exceeding $100,000 can be withdrawn from retirement accounts without the 10% penalty. COVIDTRA also extends the measure, which allows retirement savers to borrow up to $100,000 from their 401(k) accounts and to defer payments on the loan in the case of non-COVID disasters, such as hurricanes or wildfires. However, to avail of these measures, individuals must meet the guidance of residing in a qualified disaster area and prove suffering an economic loss due to the disaster.

On April 6, 2022, the U.S. Department of Education (ED) extended the student loan payment pause through Aug. 31, 2022.

The pause includes the following relief measures for eligible loans:

- a suspension of loan payments
- a 0% interest rate
- stopped collections on defaulted loans

Once the payment pause ends, students will receive their billing statement or other notice at least 21 days before payment is due. This notice will include their payment

amount and due date. In the meantime, students can get an estimate of their payment amount and due date through their loan servicer.

The Retirement Improvement and Savings Enhancement (RISE) Act

The Retirement Improvement and Savings Enhancement (RISE) Act of 2021 (H.R. 5891) 'was introduced in early November of 2021. The RISE Act includes provisions that have been introduced in separate pieces of legislation, including the Securing a Strong Retirement Act, often referred to as "SECURE 2.0," in a reference to 2019's Setting Every Community Up for Retirement Enhancement (SECURE) Act. According to a fact sheet about the RISE Act, the bill would:

- Establish an online, searchable "Retirement Lost and Found" database at the Department of Labor (DOL) to help workers locate their retirement savings as they move from job to job;
- Allow 403(b) retirement plans to participate in multiple employer plans (MEPs) and pooled employer plans (PEPs);
- Ensure more part-time workers are offered opportunities to join retirement savings plans;
- Clarify rules regarding the recovery of inadvertent overpayments to retirees, minimizing hardships;
- Enable employers to provide small financial incentives, such as low-dollar gift cards, to incentivize workers' participation in retirement plans; and
- Simplify and clarify reporting and disclosure requirements related to retirement plans.

Social Security Benefits and Customary Private Employee Benefits

DISABILITY BENEFITS	
Social Security Benefits	**Customary Private Employee Benefits**
Benefits All employees and self-employed persons are eligible. Special systems exist for railroad employees, federal government employees, and many employees of state and local governments. Disability benefits are payable to a worker whose disability is expected to last at least 12 months or result in death. The disability benefit equals the retirement benefit the worker would receive at age 66 + 10 months based on present earnings.	**Benefits** **Short-term disability** is commonly offered to all employees and is mandatory in a few states (California, Hawaii, New Jersey, New York, Rhode Island, and the US territory of Puerto Rico). The benefit can be a percentage of earnings or a flat amount. A typical short-term disability period is 13-26 weeks. Short-term disability may be self-funded or insured. **Long-term disability** coverage is not as common as short-term disability coverage, but is a popular benefit, particularly for salaried employees. The benefit period usually extends to age 65 with benefits based upon a percentage of the employee's monthly earnings and is often written in conjunction with short-term disability coverage (if insured).
Waiting Period 5 months	**Waiting Period** Generally, an employee will be required to satisfy a waiting period before disability benefits will begin being paid. During the waiting period, employees are likely to use sick leave, vacation, or personal leave If an employee is collecting disability benefits and the duration of the disability exceeded the limits of the short-term policy, the employee would probably begin collecting under a long-term disability plan (if offered) or benefits would terminate.

Social Security Benefits and Customary Private Employee Benefits

DEATH BENEFITS	
Social Security Benefits	**Customary Private Employee Benefits**
Benefits Social Security may pay out two types of death benefits: a one-time death payment of USD 255, and/or a payment which provides a monthly survivor benefit. Survivors' benefits are available for widows, dependent widowers, and orphans, and are reduced from 100% of the pension the deceased worker would have received depending on the age of the surviving spouse and other benefits received. The number of credits needed to provide benefits for survivors depends on the age of the worker at time of death. In 2022, one credit is earned for each USD 1,510of wages or self-employment income, with the possibility to earn a maximum of four credits each year. Generally, a worker needs 40 credits (10 years of work) to be eligible for any Social Security benefit. Younger workers may qualify with fewer credits. Under a special rule, if a person has worked for just one and one-half years in the three years prior to death, Social Security may pay benefits to the deceased's children and spouse who is caring for the deceased's children.	**Benefits** Employee group life insurance plans commonly include an earnings-based schedule. A typical benefit paid for by an would be one- or two-times annual salary. Often there is also an optional employee-pay-all extra amount. *Basic Life:* The traditional plan for providing employee group term life insurance coverage calls for the payment of a fixed sum on the death of an employee. Earnings based schedules are more common than flat amount schedules, with a relatively common or "basic" schedule providing a benefit equal to two times' annual salary. The flat amount schedule can fluctuate based on union bargaining agreements, employee classification, hourly wage, years of service, etc. These benefits are usually offered on a non-contributory basis by the employers. In addition to the basic group term life benefits, optional amounts can be offered in further increments of salary and are frequently 100% paid for by the employee and, therefore, purchased on a voluntary basis. *Accidental Death and Dismemberment (AD&D):* Accidental Death and Dismemberment benefits may be equal to the basic life benefits. Voluntary AD&D benefits are also available, typically providing additional amounts of coverage on an employee-pay-all basis. *Settlement Option Programs:* These programs, similar to Bank Money Market and Certificate of Deposit products, typically offer employee group life beneficiaries a timely and valuable financial service in order to manage their insurance proceeds. *Accelerated Benefits:* Accelerated Benefits are offered with the group life plan, providing payment of a portion of the life insurance benefits prior to an insured's death. A terminal illness or a determined need for long-term care is usually the condition for eligibility. *Group Universal Life (GUL):* GUL offers a face amount of coverage with the ability for participants to put money in a fund that earns a fixed rate of interest. *Group Variable Universal Life (GVUL):* GVUL offers a face amount of coverage with the ability for participants to put money in a fund that contains a fixed interest rate and variable investment options.

	Spouse benefits Most states permit **Dependent Life** benefits to be offered with the employee as beneficiary. The most prevalent benefit amount for a spouse is USD 5,000 and USD 2,000 for a dependent child.
Waiting Period Generally, Social Security will begin payment of survivors' benefits as soon as possible upon notification of death. In some cases, the special one-time death payment may be paid automatically to the survivors.	**Waiting Period** Generally, there is not a waiting period to file a death claim on group life insurance benefits.

SURVIVORS' BENEFITS	
Social Security Benefits	**Customary Private Employee Benefits**
Spouse's Pension	*Spouse's Pension*
Benefits 100% of the insured's primary insurance amount if the widow / widower of the deceased worker is age 66 + 10 months; with an incremental reduction in benefits for those between ages 60 to 66 + 10 months (71.5% at age 60). Reduced benefits (71.5%) are also available to a widow / widower between the ages of 50 and 59 if disabled. A surviving spouse age 60 or under can receive 75% if caring for a child under age 16 unless the child is disabled before age 22 (Maximum Family Benefits apply). If the widow or widower receiving survivors' benefits remarries before age 60, benefits cease.	**Benefits** **Survivor Income Benefits (SIB),** (also known as Widows' and Orphans' Benefits) are available, but much less frequently purchased. Instead of defining the insurance benefit in terms of a lump-sum, SIB defines the benefit as a specified amount of monthly income payable for a specified period to survivors of deceased employees.
Orphans' Pension	*Orphans' Pension*
Benefits 75% of the primary insurance amount is payable to the child of a deceased worker. The widow's pension is reduced to 75% of what it would have been in this case. To be eligible, a child must be under age 18, or age 19 if in high school, or disabled before age 22. For more than one child and mother, the Maximum Family Benefit applies	**Benefits** See Spouse's Pension
Maximum Family Benefit	*Maximum Family Benefit*
Benefits The total amount of benefits that all members of one family may receive, based on the earnings record of one worker, is limited to an amount that varies with the PIA (Primary Insurance Amounts). For the family of a worker who becomes age 62 or dies in 2022 before attaining age 62, the total amount of benefits payable will be computed so that it does not exceed: (a) 150% of the first USD 1,308 of the worker's PIA, plus (b) 272% of the worker's PIA over USD 1,308 through USD 1,889, plus (c) 134% of the worker's PIA over USD 1,889 through USD 2,463, plus (d) 175% of the worker's PIA over USD 2,395. For disabled persons, the Maximum Family Benefit (MFB) is the smaller of (a) 150% of the PIA, or (b) 85% of the AIME (Average Indexed Monthly Earnings), but not less than the PIA. The MFB is also increased annually to reflect changes in the cost of living.	**Benefits** Maximum Family Benefit can vary between 150-180% of the deceased worker's benefit amount. The rules are complex and affect beneficiaries in different ways, depending on their earnings levels and benefit types.'

MEDICAL BENEFITS

Social Security Benefits	Customary Private Employee Benefits
Benefits **Medicare** *Part A – Hospitalization* Part A helps individuals cover inpatient care in hospitals. It also helps cover hospice care and home health care. Most people automatically get Part A coverage without paying a monthly premium because they or a spouse paid Medicare taxes while working. Benefits covered include: **a)** **Hospital Care** - Patient pays an initial deductible (equal to USD 1,556 in 2022). After 60 inpatient hospital days, the patient pays USD 389 per day for 30 days. There is a choice after 90 days to pay USD 778 per day up to 60 "lifetime reserve" days. **b)** **Post-Hospital Skilled Nursing Facility Benefits** - If qualified, insured pays zero in 2022 for the first 20 days, then USD 194.50 per day for the next 80 days. Medicare pays all remaining charges which are recognized. After 100 days of care in a "benefit period", no benefits are paid. Custodial care is not covered. **c)** **Post-Hospital Care in Home** - Unlimited visits are permitted under a plan of treatment established by the doctor. Includes part-time nursing care, physical therapy, medical supplies, and rehabilitation equipment; does not include drugs. Custodial care is not covered. **d)** **Hospice Care** - Hospice care for terminally ill beneficiaries with a life expectancy of six months or less is covered, if the beneficiary elects hospice instead of most other medical benefits. Hospice benefits include nursing care, therapies, medical and social services, medical supplies or appliances, physicians' services, and short-term inpatient care. This benefit can be elected for two periods of 90 days each, followed by an unlimited number of 60-day benefit periods. The hospice benefits will be available beyond the first 90-day period only if recertification is made that the illness is terminal. The insured pays no more than USD 5 co-payment for prescription drugs, and 5% co-payment for respite care, but not more than the hospital deductible (i.e., USD 1,556 in 2022 in total for a period of hospice care.	**Benefits** *Indemnity programs* In a **comprehensive plan**, the deductible and co-insurance features are usually applied without differentiation between "basic" and "supplementary" expenses, as discussed below. A **base plan** may provide a benefit for hospital room and board, surgical benefits, in-hospital medical services, and laboratory fees and x-rays. A **supplementary plan** may provide additional coverage. Under health care reform these plans must offer some additional benefits (such as preventive care) unless grandfathered. *Managed care* Managed care is widely used to control overutilization of benefits and health plan costs. Although managed care takes on many forms, typically, a partnership is formed with the employer, utilizing various flexible plan design features, network alternatives such as Health Maintenance Organizations and Preferred Provider Organizations, and cost containment and utilization review programs in order to provide the best quality health plan while achieving management over costs. • **Health Maintenance Organizations (HMOs)** provide comprehensive health care services for their members for a fixed periodic payment. Benefits are typically only paid for services rendered within the HMO provider network. A primary care physician gatekeeper refers members to specialist care or hospitalization when appropriate. • **Preferred Provider Organizations (PPOs)** provide health care "at a discount" through a network of participating physicians and hospitals. Members may use providers outside the network at a higher cost, and referrals to specialist care generally are not required. PPOs are the most common type of plan offered by employers. • **Point-of-Service (POS)** programs blend aspects of both HMOs and PPOs. Like an HMO, participants select a primary care physician, but like a PPO, participants may use an out-of-network provider for health services (at a higher cost). *Consumer-directed health plans* Consumer-directed health plans provide health care services for their members generally by combining high-deductible health plans and enhanced information about quality of care with employer- and/or employee-funded pre-tax health savings accounts (HSAs) or other funding

Part B – Supplementary Medical

The benefits covered under Part B include doctors' and surgeons' fees, diagnostic services, X-rays and other radiation therapy, ambulance service, and physical therapy.

Qualifying Criteria: Age 65.

If an individual enrolls in Part B at the earliest opportunity, he or she pays a monthly premium. As of January 1, 2022, most individuals pay the standard premium of USD 170.10. For people in higher-income brackets, this premium amount increases on a graduated scale, with individuals with annual incomes over USD 500,000 paying the highest premiums. The premium increases were phased in over three years, beginning in 2007. Annual premium increases occur every January.

The plan covers 80% (or 100% where noted) of the reasonable costs for covered items. In 2022 the patient pays a deductible equal to the first USD 233 (increased from USD 203 in 2021) of charges allowable by Medicare per year and 20% of the Medicare-approved amount after the deductible.

a) **Doctors' and Surgeons' Fees** – Generally covered at 80%; however, the plan pays 100% of reasonable charges by radiologists or pathologists for services to hospital in-patients.

b) **X-Rays, Lab Tests and Other Radiation Therapy**.

c) **Diagnostic Services** – Provides for out-patient hospital diagnostic services plus diagnostic X-rays, laboratory tests, and certain X-ray tests in the home. Plan pays 100%.

d) **Artificial Devices** – Provides for braces to replace or support internal body organs, as well as artificial arms, legs, and eyes. The rental or purchase of durable equipment (e.g., wheelchair) is also covered.

e) **Ambulance Services.**

f) **Physical Therapy, Occupational Therapy, and Speech Pathology.**

g) **Hospital and Extended Care Services** – Certain services for in-patients are not covered under the base plan.

h) **Home Health Services**, if an individual does not have Part A.

mechanisms. HSAs are individual accounts that allow employees participating in qualifying high-deductible health plans to make or receive tax-free contributions and receive tax-free distributions, if used to pay for qualified medical expenses.

Other health benefits

Includes the following:

a) **Dental:** Dental services include preventive care, restorative care, diagnostic and therapeutic services, and supplementary services that include prosthodontic services and/or orthodontic services. In a comprehensive plan, benefits are based on reasonable and customary charges within a particular geographical area. Cost sharing may include a deductible (USD 50 for individual coverage or USD 150 for family coverage) and co-insurance. Preventive care is typically excluded from cost sharing by design (and in some cases federal mandate).

b) **Prescription Drug Plans:** Benefits for prescribed drugs and medicines can be provided on a service basis at the time the prescription is obtained. A co-payment or co-insurance by the covered individual for each prescription is usually required. Co-payments in a typical 3-tier retail design average about USD 11 for generic medications, USD 35 for preferred brand-name drugs, and USD 62 for non-preferred brand-name drugs. Employees using mail order pharmacies have lower co-pays.

c) **Vision Care:** Pays for eye exams, corrective lenses, and frames in an amount up to the actual fee, but not in excess of the schedule of benefits. Vision care may also consist of discounted fees for using selected providers.

d) **Mental Health and Substance Use Disorders (Behavioral Health Benefits):** While the majority of employers continue to provide mental health and substance use disorder (MH/SUD) benefits through their medical plans, some employers have carved out behavioral health benefits from their medical plan and provide them through a separate plan. Federal law requires that, if offered, mental health benefits have parity with surgical/medical benefits in cost sharing and other aspects.

e) **Employee Assistance Programs (EAPs):** Employee assistance programs provide support for employees' work-related or personal problems. Most employers who offer EAPs contract with a separate vendor to provide services, which typically include short-term counseling and referrals.

f) **Health Promotion Programs:** There has been a strong trend toward promoting consumer health and

i) **Additional Services and Supplies** – Certain services and supplies furnished in connection with a doctor's services.

j) **Screening tests and preventive physical exams** – an annual "personalized prevention plan," which includes a comprehensive health risk assessment. The personalized plan will recommend preventive services and screenings. Many of these benefits are covered at 100%.

k) **Blood for transfusions**, after the first three pints per year.

l) **Non-routine Vision Services** by qualified optometrists if they would be covered if performed by a physician.

Part C – Medicare Advantage Plans

An individual may be able to enroll in a private plan approved by Medicare, such as a managed care plan or private fee-for-service plan. Benefits include all Part A and Part B benefits and may include enhanced benefits such as vision care and prescription drug benefits. Premium rates vary by location.

Part D – Prescription Drug Coverage

Part D subsidizes prescription drug coverage provided through private insurance companies and/or managed care organizations such as HMOs.

Voluntary prescription drug benefits are available through Medicare-approved private prescription drug plans.

Benefits provided in 2022:

USD 0 to USD 480 of drug costs – enrollee pays 100% and Medicare pays nothing; USD 480 to USD 4,430 of drug costs – Medicare pays 75% and enrollee pays 25%; USD 4,131 of drug costs until enrollee has USD 7,050 out-of-pocket costs (USD 10,012.50 in costs if without employer coverage) – enrollee pays 25% and Medicare pays 75% (the coverage gap); above USD 7,050 in out-of-pocket costs – Medicare pays 95% and enrollee pays the greater of 5% or USD 3.95 generic/USD 9.85 non-generic co-pay.

Premiums vary by location and plan selected. Beginning in 2011, the premium amounts increase annually on a graduated scale based on income. In 2022, individuals with annual incomes over USD 500,000 (USD 750,000 for joint filers) pay the highest premiums. Enrollees with limited savings and incomes below 135% of the federal poverty line have no deductible; co-pays of USD 3.95 per generic prescription (USD 9.85 non-generic), up to the general out-of-pocket limit; USD 0 co-pay for all prescriptions once the out-of-pocket limit is reached.

Enrollees with limited savings and incomes below 150% of the federal poverty level have a USD 92 deductible; co-pays of

well-being. In typical health promotion programs, insurance carriers work with clients (employers) to improve employee health and change behavior, e.g., through blood pressure screening, diabetes screening, tobacco cessation campaigns, exercise programs, weight control, and nutrition programs. When designing health promotion programs, employers should consider legal parameters, including applicable federal and state insurance laws.

g) **Flexible Benefits:** Flexible benefits (also referred to as cafeteria plans) are commonly offered by employers. Design of such plans varies, of course, but most companies provide a core of basic benefits. The employee, in addition to the core benefits, may have a flexible benefit allowance which he or she may use to purchase other optional forms of benefits, including a richer health plan, additional amounts of life insurance, additional vacation days, child day-care, etc.

h) **Long-Term Care:** Long-term care insurance is designed to offer protection against the potentially catastrophic costs of long-term care, beyond the limited coverage offered by Medicare and private health insurance. It is designed to cover care in a nursing home or home- or community-based setting, helping with the activities of daily living (i.e., eating, bathing, dressing, etc.). Coverage is available as individual policies, association group policies, and employer-sponsored group policies.

A typical group plan might provide for 100% reimbursement up to a selected maximum daily benefit (e.g., USD 150 for nursing home and USD 100 for home services). As premiums are age-based, individuals who sign up at an earlier age (in their forties, for instance) would pay lower premiums.

15% up to the general out-of-pocket limit; co-pays of USD 3.95 generic (USD 9.85 non-generic) thereafter.	
Eligibility Unlike many countries, the government-sponsored health care system is very limited. The health benefits are available only to retirees, with minor exceptions (such as kidney disease). Medicare is divided into four parts, described below. *Part A – Hospitalization* Most people automatically get Part A coverage without paying a monthly premium because they or a spouse paid Medicare taxes while working. An individual must be age 65 or over and eligible for old-age or survivor benefits or have received disability benefits for 24 months. (If not eligible, a person can pay a premium to be covered.) The covered benefits include hospital care and post care in recognized facilities. *Part B – Supplementary Medical* To be eligible, an individual must be age 65 or over or have received disability benefits for 24 months. The individual must pay premiums. If an individual enrolls in Part B at the earliest opportunity, he or she pays a monthly premium. As of January 1, 2022, most individuals pay the standard premium of USD 170.10. For people in higher-income brackets, this premium amount increases on a graduated scale, with individuals with annual incomes over USD 500,000 (USD 750,000 for joint filers) paying the highest premiums. The premium increases were phased in over three years, beginning in 2007. Annual premium increases occur every January. The plan covers 80% (or 100% where noted) of the reasonable costs for covered items. In 2022, the patient pays the first USD 233 (increased from USD 203 in 2021) of charges allowable by Medicare per year and 20% of the Medicare approved amount after the deductible. *Part C – Medicare Advantage Plans* To be eligible, an individual must be age 65 or over or have received disability benefits for 24 months. The individual may or may not pay premiums. Premium rates vary by location. *Part D – Prescription Drug Coverage* To be eligible, an individual must be age 65 or over or received disability benefits for 24 months. The individual must pay premiums. Premiums vary by location and plan selected.	**Eligibility** The private sector has typically assumed the role of offering health coverage to employees and their families. A very broad spectrum of health insurance products with various benefit levels and corresponding costs has evolved to suit geographical areas and differing industrial needs. Many larger employers self-fund their health plans or portions of them, often with stop-loss coverage. A comprehensive health care reform law enacted in 2010 continues to influence this landscape.

Customary Private Employee Benefits
Additional Information:

Health and Welfare Benefit Plans:

The private sector has typically assumed the role of offering health coverage to employees and their families, particularly for people who are not eligible for Medicaid, a public program for low-income individuals. A very broad spectrum of health insurance products with various benefit levels and corresponding costs has evolved to suit geographical areas and differing industrial needs. Continued interest by the current administration, policymakers, and advocates in replacing or reshaping a 2010 health care reform law is expected to influence this landscape.

In addition to ERISA requirements, other federal laws also apply to employee benefits (particularly health plans), including portions of the Internal Revenue Code. While historically health and welfare benefits have been less regulated by federal law than retirement benefits, the landscape has changed for health benefits – most significantly by the 2010 passage of federal health care reform, known as the Affordable Care Act (ACA).

Health Legislation Developments (As of April 2022)

The Affordable Care Act (ACA)

The ACA applies broadly to private and public employers. It imposes various conditions on employer-sponsored plans and assessments on large employers who do not offer coverage to their full-time employees (defined as those averaging 30 or more hours of work per week) if at least one full-time employee gets federal subsidies toward public exchange coverage.

Virtually all individuals living in the US can obtain individual coverage on a guaranteed issue basis, with some qualifying for federal subsidies, in the public exchange established by the ACA.

Key substantive requirements applicable to employer-provided plans include:

- Bans on annual or lifetime limits on "essential health benefits."
- Maximum 90 day waiting periods
- Ban on preexisting condition limitations
- Coverage of children to age 26
- Ban on discrimination based on race, color, national origin, sex, age, or disability in health programs and activities that receive federal funds
- For non-grandfathered plans — annual cost-sharing limitations, required first-dollar coverage for preventive services, enhanced claims and appeal rights, specific emergency service provisions, right to participate in clinical trials

After their efforts to repeal the ACA were unsuccessful, Republican lawmakers successfully abolished the ACA's individual mandate penalty as part of the tax bill they passed in late 2017. As a result, since January 2019, there is no longer a federal penalty for being uninsured. However, in an attempt to stabilize their health insurance exchanges, states including California, Rhode Island, Massachusetts, New Jersey, Vermont and the District of Columbia impose their own state mandates.

In June 2021, the Supreme Court rejected an appeals court ruling challenging the legality of the individual mandate. A panel of the US Court of Appeals for the 5th Circuit Court ruled in mid-December 2019 that the ACA individual mandate was unconstitutional. It did not, however, determine if the entire ACA was valid. It instead remanded the case back to the District Court to decide whether other parts of the Act could survive without the individual mandate. The case was appealed to the US Supreme Court in early January 2020 and was rejected by the court with a 7-2 majority in June 2021. The court ruled that the plaintiffs could not demonstrate any injury resulting from the individual mandate rule and therefore did not have sufficient legal standing to sue. The Supreme Court decision closes out the significant legal challenges to ACA, and in a statement following the ruling, President Biden indicated that it is time to move forward and expand the Act further.

The Biden Administration has made it a priority to continue to strengthen the ACA. President Biden is committed to building on the progress made by the ACA by reducing premiums for the millions of Americans enrolled in Marketplace coverage and closing the Medicaid coverage gap, which would lead to four million uninsured people gaining coverage. Over 18.7 million adults are now covered across 39 states (including the District of Columbia) due to Medicaid expansion, though 12 states have not expanded.

Furthermore, they allowed states to expand Medicaid eligibility up to 138% of the Federal Poverty Level ($17,774 for an individual; $36,570 for a family of four) and remove categorical requirements that previously prevented many low-income people from being able to enroll in the program. Medicaid expansion – adopted by 38 states and Washington DC, as of March 2022, has connected people to coverage and improved health outcomes for women of color and families.

Additionally, the Biden Administration announced a record-breaking 14.5 million people have signed up for 2022 health care coverage through the Marketplaces during the historic Marketplace Open Enrollment Period (OEP) from November 1, 2021 through January 15, 2022.

Lastly, the Biden Administration recently announced a new Special Enrollment Period (SEP) opportunity for low-income consumers with household incomes under 150% of the Federal Poverty Level who are eligible for premium tax credits under the ACA and American Rescue Plan (ARP), which is approximately $19,000 for an individual and $40,000 for a family of four in 2022. In states that use the HealthCare.gov platform, 45% of consumers who signed up for health coverage during the 2021 SEP had household incomes under 150% of the Federal Poverty Level. This new SEP will make it easier for low-income people to enroll in Marketplace coverage throughout the year and benefit from the ARP savings.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires organizations working in health care to implement controls to safeguard the protected health information (PHI) of plan participants. HIPAA decrees that these organizations, known as "covered entities" (i.e. any health care provider, health plan, or health data clearinghouse), comply with newly introduced requirements, including implementing technical, physical and administrative safeguards and conducting six annual self-audits. These rules also apply to any vendors (known as "Business Associates") engaged by the covered entity to provide services that involve access to PHI. While a group health plan is considered a covered entity, it is a separate legal entity from the employer offering the plan or other sponsors of the group health plan. Employers providing health coverage via an insurance policy are therefore not responsible for HIPAA compliance unless their business falls under the definition of a covered entity or business associate. However, most self-funded health plans are subject to HIPAA compliance.

2021 has seen some legislative development regarding HIPAA with an amendment to the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) enacted in January (H.R.7898 – 116th Congress). The amendment requires the Department of Health and Human Services (HHS) to assess the use of recognized security practices by a covered entity or business associate in the case of resolving potential violations, evaluating fines, and conducting audits. It is also expected that following a relaxation of President Biden's Regulatory Freeze Pending Review, several proposed regulations, which include amendments to HIPAA requirements, will advance.

Employee Retirement Income Security Act (ERISA) Covered Plans

ERISA applies to employer-sponsored health coverage, life and disability insurance, some severance plans, and other types of welfare benefit plans. But some plans are not covered by ERISA, including, for example, plans maintained by federal, state, and local governments and most church plans.

ERISA imposes numerous requirements related to plan documents, administration, and duties of plan fiduciaries. Required reporting includes annually filing Form 5500 with the US Department of Labor (DOL), although some plans are exempted. Numerous disclosure requirements to plan participants and beneficiaries also apply to ERISA plans.

Enhanced procedures for ERISA disability claims and appeals took effect in April 2018. The DOL rule extends to ERISA disability claims procedural protections similar to ACA standards for health plans. In March 2019, a judge in the District of Columbia found major provisions in a proposed DOL rule modifying the definition of "employer" under ERISA to expand the availability of association health plans (AHPs) to be unlawful. The rule's interpretation to make it easier for small businesses and "working owners" to form employer groups or associations that offer large group health plans exempt from some requirements (such as covering certain "essential health benefits" and community rating rules) that the ACA imposes on the small group and individual markets were deemed to have unreasonable interpretations of ERISA. The modified employer definition would apply only to health benefits and would not change prior guidance on other ERISA benefits. On April 26, 2019, the DOL filed a notice of appeal to the court's ruling, with the first oral arguments heard in November 2020.

Internal Revenue Code Requirements

The Internal Revenue Code has provisions applying to certain types of health and welfare plans, including some not subject to ERISA. For example, under IRS nondiscrimination rules, some health and welfare plans (e.g., self-insured health plans, group term life insurance, cafeteria plans, and dependent care assistance plans) receive tax-favored treatment only if provided to a broad segment of employees that includes adequate representation of the non-highly paid. Nondiscrimination rules also will apply to insured group health plans if the Internal Revenue Service releases guidance.

Other Federal Mandates Applying to Employer Group Health Plans

Numerous other federal mandates apply to most employer-sponsored health coverage:

- Special enrollment rights if other coverage is lost or new dependents are gained
- Required parity between mental health and substance abuse benefits and medical/surgical benefits
- Detailed rules to ensure wellness programs do not discriminate against those with adverse health factors
- Other health status nondiscrimination, including genetic nondiscrimination
- Privacy and security standards

A number of these and other federal mandates have disclosure requirements.

As the opioid crisis continues to garner the attention of lawmakers, there is a renewed focus on mental health and substance abuse benefit parity and a promise of increased enforcement in employer-sponsored plans. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) levied equality for mental health and substance use services to prohibit group plans from imposing less favorable limits than those set for physical health conditions. However, implementation across group plans has been mixed, and there has been evidence of "discriminatory practices" regarding non-quantitative treatments. The DOL can require employers to reimburse their employees for parity violations on self-funded insurance plans but currently cannot act against the insurance company itself. The Consolidated Appropriations Act, 2021 (CAA) (H.R.133 – 116th) included a provision to expand the compliance requirements under MHPAEA to guarantee equal coverage limits for mental health and substance use disorder benefits and medical and surgical benefits. Employer-sponsored group health plans must monitor their compliance with MHPAEA, with the DOL releasing an online self-compliance tool to help plan sponsors and administrator’s complete compliance audits.

Group health plans are also subject to broader federal laws prohibiting discrimination, such as Title VII (which prohibits workplace discrimination on the basis of race, sex, religion and certain other protected categories); the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA); and the Age Discrimination in Employment Act (ADEA). Compliance with ERISA, the ACA and other mandates specific to health plans does not necessarily ensure compliance with these broader laws.

Separately, the Equal Employment Opportunity Commission (EEOC) (the agency that enforces the ADA, GINA, and Title VII, among other federal laws) and plaintiffs asserted that Title VII's ban on sex discrimination extends to discrimination based on sexual orientation or gender identity. In June 2020, the Supreme Court ruled in favor of the plaintiffs of three cases involving individuals who alleged unfair dismissal from their employment due to their LGBT status. The judges cited that federal law prohibits discrimination based on sex, including an individual's sexual orientation and gender identity. The Equality Act (HR 5) would update civil rights legislation to protect individuals' sexual orientation and gender identity in the same manner as race, sex, religion, and national origin.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 introduced Federal legislation which prohibits health insurance plans offering maternity coverage from restricting benefits for hospital stays following childbirth to less than 48 hours (96 hours in the case of a cesarean section). Every group plan which provides maternity or newborn coverage must provide a disclosure notification of these rights to the plan beneficiaries. It should be noted that many states have enacted their own version of the law regulating coverage for mothers and newborns, which may differ slightly from federal law and, in some instances, may supersede federal requirements.

A newborn is covered under the mother's policy and deductible for just the first 30 days following birth. However, under the ACA, a birth is deemed a qualifying life event. It triggers a 60-day special enrollment period allowing for an application or change request for health insurance coverage to enroll the infant.

COBRA

The "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA) requires that most employers sponsoring group health plans offer employees and their dependents continued health care coverage in certain circumstances, such as termination of employment or divorce, when coverage under the plan would otherwise end. The continuation period ranges from 18 to 36 months, depending on the event. In the event of unemployment, the cost of COBRA coverage is borne by the individual, with no contribution from the employer. Although COBRA and its associated compliance obligations remain in effect, the availability of individual coverage through the public exchange may reduce the number of individuals electing COBRA.

As part of the American Rescue Plan Act of 2021 (ARPA) (H.R.1319), a 100% premium COBRA subsidy and additional COBRA enrollment rights were introduced for 'assistance eligible individuals' (AEIs), which includes individuals who were affected by an involuntary termination or a reduction in work hours. Between April 1, 2021, and September 30, 2021, group health plans offering COBRA coverage are required to offer AEIs and their beneficiaries a 100% subsidy of COBRA premiums. The premium is covered by either the plan or the employer and will be reimbursed through a refundable credit against payroll taxes. In addition, individuals who have previously opted out of COBRA or who had previously dropped out of coverage must be notified by employers of the opportunity to opt back in. The maximum eligibility period of COBRA can extend to 36 months under certain qualifying events, meaning that employers will need to notify individuals who became eligible for coverage from April 1, 2018, to guarantee compliance with ARPA.

Legal clarity pending for employer wellness plans

In 2016, the American Association of Retired Persons (AARP) sued the EEOC over their assertion that employers with wellness plans could offer the higher incentives permitted by the ACA and request family members provide certain medical information without violating the ADA or GINA. In December 2018, the EEOC reversed its prior stance by vacating the incentive provisions of its final wellness program regulations, effective from January 1, 2019. The current law does not expressly prohibit or permit offering incentives to participate in a wellness program. However, employers need to structure their wellness programs to ensure compliance with the EEOC rules, with awareness around incentives subject to ADA or GINA.

On January 7, 2021, the EEOC released new Notices of Proposed Rulemaking for wellness incentives under ADA and GINA. The rules state that employers may not offer more than a minimum incentive (such as a gift card of modest value) to encourage employee participation in voluntary wellness programs if those programs collect personal medical data of the employee through disability-related inquires or medical exams. An exception to this is a health-contingent wellness program that either qualifies as or is part of a group health plan. Under the ADA safe-harbor rule, group health plans can provide incentives of up to 30% cost of coverage (50% for tobacco cessation programs) if the plan complies with HIPAA requirements. In addition, wellness programs that do not require disability-related inquires or medical exams are exempted from the proposed rule.

However, the EEOC's Notices of Proposed Rulemaking were suspended on January 20 by the Biden Administration as part of the regulatory freeze until the newly appointed EEOC chair reviews and approves the proposals. As a result, the EEOC formally withdrew the recommendations from the Federal Register. Yet, there is no indication if the proposals will be finalized in their original state or if they will be subject to revision.

Health Savings Accounts (HSAs) see growth in 2020

According to Devenir Research, with more than 31 million health savings accounts holding nearly $93 billion in assets as of midyear 2021, HSAs and their place in the market have continued to evolve at a rapid clip. Additionally, as of the end of January 2022, participants saved more than $100 billion in over 33 million HSAs. Employee contributions increased 10% from 2019, with the average balance in an HSA account rising by 17%. While there is currently insufficient data to determine how much the pandemic played a role in the growth of contribution levels, many employees deferred non-essential medical care during this period which likely influenced the accrual of account assets. The Health Savings Act of 2021 (S.380), introduced in February 2021, aims to expand consumer opportunities to participate and contribute to HSAs. The act proposes to:

- Eliminate the annual limit on tax-deductible contributions to HSAs by individuals and their employers.
- Eliminate the requirement to be enrolled in a high-deductible health plan to make tax-free contributions to HSAs.
- Expand qualified medical expenses.
- Permit administrative, clerical or payroll contribution error corrections on or before the last day to file taxes.
- Allow the tax-free transfer of an HSA to the family after the account holder's death.
- Ensure HSAs receive equivalent bankruptcy protections as retirement funds.

Paid Family Leave

The Family and Medical Leave Act (FMLA), which has been in place since 1993, allows

eligible employees of covered companies to take up to 12 weeks of unpaid leave each year for illness or injury, care of a family member, and for the birth, adoption or foster care of a child, or military deployment of a family member. FMLA covers employers with at least 50 employees. Employees may become eligible if they worked at least 1,250 hours for a covered employer during the 12 months prior to the leave period commencing. However, a report from the DOL showed that up to two-thirds of eligible employees could not afford to take unpaid leave. In addition, the definition of family under FMLA is narrow, encompassing spouses, parents, and children under 18 only. Some states – California, Colorado, Connecticut, Massachusetts, New Jersey, New York, Oregon, Rhode Island, Washington – and the District of Columbia currently offer paid family leave programs primarily funded via payroll deductions.

Of these, Colorado and Oregon are yet to bring into effect the paid family leave program. A PFML policy is scheduled to begin September 3, 2023, in Oregon and January 1, 2024 in Colorado.

In at least two states—New Hampshire and Vermont—paid family leave passed the legislature only to be vetoed by the governor. In New Hampshire, a voluntary program will take effect in January 2023. Other states, such as Missouri and South Carolina, are currently considering legislation that would provide paid family leave only for government employees. In 2021, North Dakota passed legislation banning cities and counties from enacting local paid family leave legislation.

In April 2021, President Biden put forward the American Families Plan to Congress for consideration. The plan includes a measure to create a national comprehensive paid family and medical leave program, phased in over ten years. The program would guarantee 12 weeks of paid parental, family, and personal illness/safe leave by the tenth year, paying workers up to $4,000 a month, with a minimum of two-thirds of average weekly wages replaced, rising to 80% for the lowest wage workers. It would also ensure that employees would receive three days of bereavement leave per year starting in the program's first year. This plan would be funded by tax increases for the top 1% of income earners and increased capital gains and dividend tax rates for those who earn over $1 million per year.

The Building an Economy for Families Act was also proposed in April. This plan would provide up to 12 weeks of paid family and medical leave for all workers, replacing up to two-thirds of the employee's wages. In addition, eligibility would be extended to individuals not covered under FMLA, including part-time employees and gig workers. The act also broadens the definition of family to include domestic partners, adult children, siblings, grandparents, grandchildren and any other association by blood or affinity that is equivalent to a family relationship.

An additional piece of legislation, the Healthy Families Act (S.1195), would allow employees in a company with 15 or more workers to accrue up to seven paid sick leave days per year to address their own health needs and those of their families.

According to the Center for American Progress, of the 7 million workers without paid family and medical leave, 35.8% needed family caregiving leave but couldn't afford to take unpaid time off. 44% of individuals are not covered by the FMLA. Of those not covered, 2.6 million individuals—at some point in the year—need to take leave but don't for fear of losing their jobs. Of women without paid leave, 30% end up leaving their jobs after giving birth.

The U.S. House of Representatives recently passed a program that would provide four weeks of paid family and sick leave to many workers beginning in 2024. The Biden administration has made this legislation a priority, originally proposing 12 weeks of paid family leave in the Build Back Better Act. After briefly jettisoning paid family leave altogether, the House passed a slimmed-down version on November 19, 2021. It now faces an uncertain future at the Senate.

The No Surprise Act

Beginning January 1, 2022, new federal protections backed by the Biden Administration will protect millions of consumers from surprise medical bills—unexpected bills from an out-of-network provider, out-of-network facility or out-of-network air ambulance provider. The protections, implemented under the No Surprises Act, ban surprise billing in private insurance for most emergency care and many instances of non-emergency care. They also require that uninsured and self-pay patients receive key information, including overviews of anticipated costs and details about their rights.

In addition to shielding millions of consumers from surprise medical bills, these protections will further President Biden's work to promote competition in health care and other sectors of the American economy.

For Insured Individuals, Protections from Surprise Medical Bills

For people who have health coverage through an employer, a Health Insurance Marketplace, or an individual health plan purchased directly from an insurer, the rules that took effect January 1, 2022:

- Bans surprise bills any time you receive emergency care, and require that cost sharing for these services, like co-pays, always be based on in-network rates, even when care is received without prior authorization.
- Bans surprise bills from certain out-of-network providers if you go to an in-network hospital for a procedure. This means cost sharing for certain additional services during your visit will generally be based on in-network rates.
- Requires providers and facilities to share with patients easy-to-understand notices that explain the applicable billing protections and who to contact if they have concerns that a provider or facility has violated the new surprise billing protections.

For Uninsured Individuals, Better Advanced Knowledge of Costs

For people who do not have health insurance or pay for care on their own (also known as "self-paying"), the rules that took effect January 1, 2022, require most providers to give a "good faith estimate" of costs before providing non-emergency care.

The good faith estimate must include expected charges for the primary item or service, as well as any other items or services that would reasonably be expected. For an uninsured or self-pay consumer getting surgery, for example, the estimate would include the cost of the surgery, as well as any labs, other tests, and anaesthesia that might be used during the procedure. Uninsured or self-pay consumers who receive a final bill that exceeds the good faith estimate by $400 or more can dispute the final charges.

Type of Insurance	Contributions	Benefits
Qualified Retirement Plan & Retirement Plan Distributions	*Employer:* An employer maintaining a defined benefit or money purchase pension plan generally has 8½ months after the end of the plan year to make contributions necessary to avoid a funding deficiency and a penalty. The employer avoids the interest charge by making contributions in four installments that equal the lesser of the previous year's minimum funding requirement or 90% of the current year's requirement. However, a defined benefit plan generally will not be subject to the quarterly payment requirements if the plan had no funding shortfall for the prior year. Contributions to the pension and/or profit sharing and other defined contribution plans are deductible on its corporate tax return (subject to certain limitations)	*Employer:* When a benefit is paid to an employee or beneficiary, the distribution is taxable.
	Employee: If an employee's elective contributions under a 401(k) cash or deferred arrangement are made on a pre-tax basis, the contributions and related earnings are exempt from taxation until distributed by the plan. However, if the contributions are Roth contributions (a special type of after-tax contribution), the related earnings are tax-free upon distribution if they remain in the plan long enough. Pre-tax, Roth and all other voluntary employee contributions (for example, non-Roth after-tax contributions), and mandatory contributions (for example, to a contributory defined benefit plan), are not deductible on personal tax filings. 20% tax withholding applies to any distribution of pre-tax amounts eligible for rollover unless the taxable amount is rolled over directly to another qualified plan or individual retirement account (IRA).	*Employee:* Any qualified retirement plan benefits that are derived from contributions (employer and employee) and investment income not previously taxed (with the exception of qualified distributions of investment income from a Roth account), will be taxed when the benefits are distributed. Generally, benefits distributed prior to attaining age 59½ will be subject to an additional 10% penalty tax (unless the employee terminates employment and is age 55 or older). In 2022, an employee may defer up to a maximum of USD 20,500 in this manner (a combined limit for pre-tax and Roth elective contributions). 401(k) plans also may allow employees who will attain age 50 by the end of the year an opportunity to make additional "catch-up" contributions of USD 6,500 in 2022.

Group life, disability, and medical plans	*Employer:* Premiums paid by an employer for group life, disability, and medical plans are a fully deductible business expense.	*Employer:* When a benefit is paid to an employee or beneficiary, the distribution is not taxable to the employer.
	Employee: Generally speaking; an employee's contributions, if any, to group life, disability, and health are not tax deductible. However, employee contributions toward such coverage may be excludible from income if made under a cafeteria plan pursuant to a valid salary reduction agreement.	*Employee:* When a benefit is paid to an employee or beneficiary, the distribution is typically not taxable to the employee.

Benchmarking Information

	%
Group Life Coverage* **	
Death benefit	82%
AD&D	83%
Disability Coverage* **	
Long term disability	71%
Short term disability	61%
Retirement Plans*	
Defined Contribution	93%
Defined Benefit	7%
Other**	
Wellness	42%
Childcare	10%
Flexible workplace	14%
Subsidized commuting	8%
Employee assistance programs	51%

*Source: Cerulli - US Retirement Markets Report, 2018**
*US Bureau of Labor Statistics, 2020***
*Society for Human Resource Management (SHRM), 2020***

Both group insurance and pension plans in the US have developed along increasingly diverse and complex lines to the extent that it is no longer possible to cite an average or normal plan. The following overview is intended to illustrate a basic outline of benefits often provided and should not be used as a basis for designing a plan for any particular group of employees.

A. Overview of Typical Plans

GROUP TERM LIFE	
Basic Life	Earnings-based schedule, typically 1-2 times salary, with additional optional coverage available
Optional Contributory Life	Options of supplementary flat or times earnings amounts
Accidental Death and Dismemberment (AD&D):	An amount usually equal to the basic life benefit.
Dependent Life:	Typically, modest amounts, such as spouse USD 5,000 and child USD 2,000
Common features of life insurance products	• Initial enrollment period: typically, 31 days after the employee's date of hire, with subsequent open enrollment periods. • Guaranteed issue limits: provide a level of coverage without medical evidence, while evidence of insurability provisions may require an insured to provide medical evidence for amounts above the guaranteed issue limit or after the initial or open enrollment period. • Waiver of premium: in the event of the insured's disability, continuing coverage for a stated period of time. Waiver of premium usually continues even if the policy is terminated by the employer. • Accelerated benefits: in the event of the insured's terminal illness or need for long-term care allow payment of a portion of the life insurance benefits prior to the insured's death. • Age reduction provisions lower the life insurance coverage amount as the insured's age increases. • Portability provisions allow terminating employees who are not retiring or disabled to continue group term life coverage, which may be at preferred premium rates. • Conversion provisions allow employees to convert group coverage to individual policy coverage upon employment termination.

GROUP DISABILITY	
Short-Term Disability (STD)	• Common benefit for all employees • Waiting period: Typically, 7 days • Benefit: Typically, 60% of base pay (may reduce to lower percentage after limited time) • Duration: 26 weeks is the most common • Mandated program in certain states and Puerto Rico
Long-Term Disability (LTD):	• Elimination period: Typically, 6 months (180 days) or STD benefit period, if integrated. • Benefit: Typically, 60% of base pay, offset by Social Security and worker's compensation, subject to a maximum, such as USD 10,000 per month. • Maximum duration: Usually until normal retirement age. Shorter periods common for mental health or nervous disabilities or alcohol or substance use disorders. • Definition of disability is commonly the employee's inability to perform the duties of the employee's own or regular occupation for the first 2 years of disability. After 2 years, disability is the inability to perform the duties of any occupation for which the individual is qualified by education, training or experience. • Increasing benefits may be provided through cost-of-living increases, or future or automatic increase riders. • Residual benefits may be paid for disabilities resulting in a partial loss of earnings, or for disabilities resulting in reduced time and duties. • Renewability features protect the policyholder from changes to benefits; with non-cancelable policies, an insurer cannot increase premiums or reduce benefits. • Disabilities related to pre-existing conditions may be excluded from coverage, and proof of continuing disability is normally required. • Return to work and rehabilitation programs may be included.

GROUP HEALTH	
Basic Indemnity Plan	*Hospital:* • Room and board: dollar amount per day or semi-private room rate, payable for a maximum number of days, such as 365. • Special hospital services: such as operating room, anesthesia, etc. *Surgical:* • Reasonable and customary charges • Scheduled maximum per procedure *In-Hospital Medical:* • Doctor's visits in the hospital *Lab Tests and X-rays:* • Reasonable and customary charges • Scheduled amount per procedure *Maternity Benefit:* • Provided on same basis as other medical expenses *Supplemental Major Medical:* • Covers expenses not covered by basic plan *Comprehensive Indemnity Plan (most typical):* • Same benefits as basic plus Supplemental • Deductible and co-insurance apply immediately *Other Benefits:* • Might include dental, prescription drugs, and vision care benefits.

Sample Employee Benefit Plans

PENSION PLAN	
Salaried Employees	• Based on career or final average earnings • Often integrated with Social Security • Fixed dollar benefits payable monthly (automatic cost-of-living adjustments are not common) • Full vesting after 5 years of service • Normal retirement age 65 • Generally attractive incentives for early retirement
Union Employees	• Based on service only, e.g., USD 40 per month at retirement for each year of service • Benefit level renegotiated every 2 to 3 years

401(k) PLAN	
Defined Contribution Plan	• Pre-tax employee contributions, after-tax voluntary contributions and Roth contributions (subject to nondiscrimination regulations and annual dollar limits). • Matching employer contribution (e.g., 25% - 50% of the first 6% of pay the employee contributes) • Participant-directed investments • Generally, 11 to 15 investment options • Loans up to the lesser of USD 50,000 or 50% of vested account balance** • Lump-sum payments at death, disability, termination, or retirement (a few plans also allow for some forms of annuities and/or installments)

B. Group Life, Disability, and Health Plans

While the following descriptions are illustrative of both small and large employers, the major difference that usually arises is in the funding methods.

Small employers typically have their plans fully insured to protect themselves from large claims fluctuations. Large employers may have funding arrangements, such as minimum premium or administrative services only (ASO), to maximize their cash flow, as well as to take on part or all of the risk of claim fluctuations. All examples assume the policy or coverage period runs on a calendar-year basis.

Specifically, regarding health plans, the following description illustrates a PPO plan with managed care/utilization review features. In the following description, the terms “you” and “your” refer to the covered employee.

SUMMARY OF BENEFITS	
Eligibility Requirements	*Eligible Class:* All full-time salaried and hourly employees (a full-time employee works an average of at least 30 hours per week) (defined by the policyholder). *Eligible Dependents:* *Qualifying child:* Children up to the age of 26. *Waiting Period:* You may enroll yourself and your dependents on the first day after 30 days of active work.
Life Insurance	Salaried: Two times base pay
Accidental Death and Dismemberment Insurance	Salaried: Two times base pay
Dependent Life Insurance	• Spouse: USD 5,000 • Child(ren), up to the age of 26: USD 2,000 The amount of your dependent’s life insurance benefit can be no greater than half the amount of your life insurance benefit.
Optional Life Insurance	Salaried: Ranges from 1 to 5 times base pay
Short-Term Disability:	*Weekly Benefit:* 60% of weekly base pay *Maximum Duration:* 26 weeks *Waiting Period:* • For sickness: 7 days (benefits begin on 8th day of disability) • For accident: 7 days • For hospitalization: 7 days
Long-Term Disability	*Waiting Period:* 180 days or STD benefit period, if integrated *Benefit:* 60% of monthly base pay, offset by Social Security, subject to a maximum, such as USD 10,000 per month

	Duration: Typically; two years or until normal retirement age, unless no longer disabled; shorter periods common for mental health or substance use disorders
Medical Coverage	*Deductible (in-network):* • Individual: USD 650 per calendar year • Family: USD 1,500 per calendar year *Co-insurance:* Percentage varies with the type of expense (see the chart that follows). *Type of Expense*: — *Plan Pays* — *You Pay* In-network patient hospital: 80% — 20% after the deductible Emergency room visit: 80% — 20% after the deductible Out-of-network physician office visit: 60% — 40% after the deductible *Out-of-Pocket Limit (in-network):* • Individual: USD 3,000 • Family: USD 6,850
Medical Plan Cost-Management Features	The medical plan includes required and recommended cost-management features. One must comply with required procedures to receive maximum benefits and/or avoid penalties. A toll-free patient advocate telephone number is available for assistance with the required procedures. Pre-admission Review: If a pre-admission review is not obtained as required, the insured may be required to pay a larger portion of covered expenses or pay a penalty. This amount will not apply to the deductible or out-of-pocket limit. Note: pre-admission reviews must conform to mental health parity rules. Second Surgical Opinion: If a required second surgical opinion is not obtained, the benefit for the surgery will be reduced by a certain percentage. Outpatient Surgery: If the insured chooses out-patient over in-patient surgery when there is a choice, the deductible will be waived, and the benefit will be increased to 100%
Dental Coverage	*Deductible:* • Individual: USD 50 (per calendar year) • Family: USD 150 (per calendar year) *Co-insurance:* Percentage varies with the type of expense (see the chart that follows): *Type of Expense:* — *Plan Pays** — *You Pay* Preventive Treatment: 100% — 0% & the deductible is waived Basic Treatment 80% — 20% after the deductible Major Treatment: 50% — 50% after the deductible

	Orthodontic Treatment:	100%	0% after the deductible **subject to benefit maximums*
	Benefit Maximums: • Orthodontic Treatment: USD 1,000 for lifetime • Preventive and Basic/Major Treatment: USD 1,500 per year		

C. Defined Benefit Plan - Manufacturing Company (1,500 lives)

This company has two defined benefit pension plans: one for union employees and one for salaried (non-union) employees.

UNION PLAN	
Eligibility	An employee is eligible to join the plan the first day of the month following the date of employment.
Cost of the Plan	The plan will be funded exclusively by the employer.
Benefit Formula	The accrued monthly benefit is based on the following schedule: 1. *Credited Service 1/1/80 - 12/31/74:* USD 8.50 per month at retirement for each year of credited service. A year of credited service is 1,800 hours of work in a calendar year. Proportionate years of credited service will be granted for less than 1,800 hours of work in a calendar year. 2. *Credited Service 1/1/85-1/1/88:* USD 10.00 per month at retirement for each year of credited service. Note: Typical of most union plans, the benefit level is renegotiated every 2 to 4 years. In this plan, the new benefit level applies prospectively. In some union plans, the new benefit level applies to all credited service for active employees. By 1/1/2000, the benefit level in this plan had risen to USD 35.00 per month at retirement for each year of credited service.
Normal Retirement	Age 65
Early Retirement	Age 55 with 10 years of service. The benefit is reduced by 0.5% for each month early retirement precedes normal retirement.
Vesting	100% vesting after 5 years of service.
Form of Payment	The normal form is a 10-year certain and life annuity for single employees. A joint and survivor 50% annuity will be paid to married participants, at an adjusted amount, unless both the participant and the spouse elect another form of payment. There is no lump-sum payment available under the plan. 75% joint and survivor coverage also is available.

NON-UNION, SALARIED PLAN	
Eligibility	Age 21 and 6 months of service
Cost of the Plan	Employer pays 100% of cost of plan
Normal Retirement Benefit	1.75% of final average earnings multiplied by years of credited service. (“Final average earnings” is defined as the highest 5 consecutive years of earnings during the last 10 years of employment.)
Normal Retirement	Age 65
Early Retirement	Age 55 with 5 years of service. The benefit is reduced actuarially for each month that early retirement precedes normal retirement.
Vesting	100% vesting after 5 years of service.

Forms of Payment	Life annuity for single employees. Reduced joint and survivor coverage, 50% for married participants, unless both the participant and spouse decline the 50% joint and survivor coverage. 75% joint & survivor coverage is also available.

Note: Typical of most plans, there is no lump-sum option at retirement. There is also no automatic cost-of-living/inflation adjustment after retirement, although this plan has periodically increased retiree benefits when there were surplus assets in the fund.

D. 401(k) Plan - Financial Institution (700 lives)

401(k) PLAN	
Eligibility	First day of the month after completion of 6 months of service.
Employee Contributions	Eligible employees may contribute from 1% to 20% of eligible compensation to the plan on a pre-tax basis. Compensation by law is limited to USD 305,000 annually (in 2022). Additionally, 401(k) plans must limit pre-tax deferrals to USD 20,500 in 2022. Employees age 50 or older may contribute up to an additional USD 6,500 in 2022.
Employer Contributions	The employer will match 50% of the first 6% of an employee's compensation contributed as a pre-tax deferral. No match on any pre-tax contributions that exceed 6%.
Profit-Sharing Contribution	At the end of the fiscal year, the employer also may make a discretionary contribution to the plan based on profits. Each participant will share in this profit-sharing contribution in the ratio that his/her compensation bears to total compensation (as defined in the plan document).
Vesting	Participants are always 100% vested in their own contributions (required by law). A participant will vest 100% in the employer-provided profit-sharing contributions and matching contributions after 3 years of service.
Investment Direction	Participants will direct the investment of all employee and employer contributions. The same investment elections must apply to all contributions in a participant's account. The investment options include a stable value fund (supported by guaranteed interest contracts), a domestic stock fund, an international stock fund, a growth stock fund, a growth and income fund, and a balanced stock and bond fund. The plan also offers lifestyle fund options, as well as managed accounts. Participants can direct investment in 1% increments into any of these investment options.
Investment Changes	Participants may change how future contributions will be invested, and/or reallocate past contributions.
Withdrawals	The plan permits participants to withdraw up to 50% of their entire vested account balance if hardship requirements are met. The withdrawal is subject to ordinary income tax and a special 10% penalty tax for early withdrawals (generally applies prior to age 59 1/2).
Loans	The plan permits participants to borrow the lesser of 50% of their vested account balance or USD 50,000. Loans are not subject to current taxation as long as they are repaid to the plan, generally within 5 years (a longer repayment period is permitted for primary residence loans).** The plan requires repayment through payroll deduction, at an interest rate that is 1% above the rate currently available in the marketplace. Participants may only have one outstanding plan loan.
Termination of Employment	At termination, participants may leave their account balance in the plan, elect to roll the funds over into an individual retirement account (IRA), elect to roll them over into a new employer's plan (if applicable), or take a lump-sum distribution. A lump-sum distribution is subject to 20% tax withholding (if rollover eligible). A special 10% penalty tax also may apply to participants under age 59 1/2 who don't roll over their lump-sums.
Death & Disability Benefits	100% of the account balance automatically vests at death or total disability.

Useful Links

For more information on Prudential, please visit:	http://www.prudential.com
International Group Program (IGP):	https://www.igpinfo.com
Social Security Benefits:	https://www.ssa.gov/
Internal Revenue Service:	https://www.irs.gov/