



Benecon
Health Benefits
Seminar *2026*

Benefits BINGO

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LET'S PLAY

BINGO!





BINGO!

UNDERSTANDING THE BINGO CARD

LAYOUT AND NUMBER DISTRIBUTION

Each Bingo card has a 5x5 grid with five columns labeled B-I-N-G-O. Each column contains phrases relating to topics we will be discussing today. The center square is a free space.





BINGO PHRASES AND CALLER

HOW THE GAME BEGINS

The caller will ask questions that correspond to answers on your Bingo cards. If you know the answer, mark the corresponding box. The answer will be revealed and explained in the following slides.



WINNING PATTERNS

BINGO OBJECTIVE

Winning patterns include horizontal, vertical, or diagonal.





CALLING "BINGO!"

HOW TO DECLARE A WIN

Once you complete the winning pattern, raise your hand and loudly call out "Bingo!"





HAVE FUN AND GOOD LUCK

Now that you know the rules and steps, it's time to join in! Grab your card, listen closely, and get ready for a fun and engaging Bingo experience.

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ARE YOU
READY TO WIN?

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**IF LOSS OF COVERAGE
OCCURS, WHAT MUST
GENERALLY BE OFFERED
FOR GROUPS WITH 20 OR
MORE EMPLOYEES?**



THE ANSWER IS...

COBRA

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WHAT IS COBRA? DO I HAVE TO OFFER IT?

COBRA stands for Consolidated Omnibus Budget Reconciliation Act. It is a federal law that allows for employees and their dependents to temporarily continue employer-sponsored group health insurance - typically for 18 to 36 months - after losing coverage due to termination of employment, reduction in hours, or other qualifying life events.

COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer continuation coverage.

Even if you are under 20 employees, you may be subject to state "mini-COBRA."



**WHAT IS REQUIRED TO
CHANGE A CAFETERIA
PLAN ELECTION MID
YEAR?**



THE ANSWER IS...

Qualifying
Life Event

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WHAT IS A QUALIFYING LIFE EVENT?

Generally, participant elections are irrevocable for the plan year unless the participant has one of the events listed out in IRS regulations and other guidance. Employers that permit these midyear election changes must have them written out in the cafeteria plan document.

These events can include marriage, birth, adoption of a child, change in residence, and change in employment status.



**WHAT TYPE OF HEALTH
PLAN IS REQUIRED TO
CONTRIBUTE TO AN HSA?**



THE ANSWER IS...

**High
Deductible
Health Plan
(HDHP)**

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WHO IS HSA ELIGIBLE?

Only an “eligible individual” can establish an HSA and make HSA contributions or have them made on their behalf. A requirement for HSA eligibility is to have coverage under a high deductible health plan (HDHP). Additionally, there must be no other disqualifying coverage. This means that an eligible individual cannot have coverage under any non-HDHP that provides coverage for any benefit covered by the HDHP.



**WHAT IS A COMMON
COMPLIANCE RISK
RELATED TO
DEPENDENTS?**



THE ANSWER IS...

**Covering
ineligible
dependents**

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WHO ARE INELIGIBLE DEPENDENTS?

Ineligible dependents are just as they sound, they are anyone enrolled in your employer-sponsored health plan who do not meet your plan's eligibility criteria. This can include:

- Divorced spouses still listed as dependents
- Aged out children
- Grandchildren, nieces, nephews, etc.

What are the issues with having ineligible dependents on the plan?

- Stop loss can deny claims for ineligible dependents
- Both you and the employee pay more for people that shouldn't be on the plan in the first place



**WHEN MUST COVERAGE
GENERALLY BECOME
EFFECTIVE FOR ELIGIBLE
EMPLOYEES?**



THE ANSWER IS...

**Within 90
days of
eligibility**

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WHAT IS A WAITING PERIOD? WHY 90 DAYS?

A waiting period is the period that must pass before coverage for an eligible individual can become effective. In 2014, the IRS, DOL, and HHS finalized regulations addressing the prohibition on excessive waiting periods for group health plans. These regulations established that a waiting period must not be in excess of 90 days from date of eligibility.



**WHAT DOCUMENT IS
NEEDED TO CONTINUE
HEALTH BENEFITS FOR
ELIGIBLE EMPLOYEES
DURING A PERIOD OF
LEAVE?**



THE ANSWER IS...

**Health
Benefit
Continuation
Policy**

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WHY DO I NEED A HEALTH BENEFIT CONTINUATION POLICY?

One of the major reasons is for stop loss purposes. Failure to have an established health benefit continuation policy can result in claims being denied if the stop loss carrier does not have documented proof that coverage was extended for an employee that was placed on leave. This can lead to major expenses! Maintain a health benefit continuation policy!!!



**WHAT ARE COMMON
DOCUMENTS USED TO
VERIFY DEPENDENT
ELIGIBILITY?**



THE ANSWER IS...

**Birth
certificate
or marriage
certificate**

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WHAT CAN WE DO TO PREVENT INELIGIBLE DEPENDENTS FROM BEING ON THE PLAN?

Most of the time, ineligible dependents get on the plan by mistake. What you can do to ensure that the dependents on your plan are supposed to be on your plan is request documentation when a dependent is added or removed from the plan. Additionally, you should be asking for verification at open enrollment to ensure the dependents coming on to your plan are eligible.

Another major prevention technique is to conduct an dependent eligibility audit.



**IF COVERAGE IS
EXTENDED AFTER
TERMINATION THROUGH AN
AGREEMENT, WHAT
DOCUMENT TYPICALLY
OUTLINES THE TERMS?**



THE ANSWER IS...

**Severance
Agreement**

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WHY SHOULD SEVERANCE AGREEMENTS ADDRESS HEALTH BENEFITS?

If a severance agreement is not properly drafted, issues with COBRA can arise in dealing with post-termination coverage under the employer's group health plan. The coordination between COBRA and a severance agreement is crucial as it can result in terminated employees staying on the group health plan longer than the employer would like.



WHAT IS THE STANDARD COBRA COVERAGE PERIOD FOR TERMINATION OF EMPLOYMENT?



THE ANSWER IS...

18 months

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HOW LONG DOES COBRA LAST?

The length of COBRA coverage is dependent on the type of event that the qualified beneficiary has and if other circumstances occur that may extend the coverage past the basic maximum coverage period.

The basic maximum coverage periods are:

18 Months

- Covered employee's termination of employment (other than for gross misconduct)
- Covered employee's reduction of hours

36 Months

- Death of the covered employee
- Divorce or separation of the covered employee from his or her spouse
- The covered employee's becoming entitled to Medicare benefits
- A dependent child's ceasing to be a dependent



**WHAT TYPE OF FSA
PRESERVES HSA
ELIGIBILITY?**



THE ANSWER IS...

**Limited
Purpose
FSA**

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WHY A LIMITED-PURPOSE FSA?

General-purpose health FSA coverage will prevent an individual from being eligible for HSA, but IRS guidance has confirmed that if an eligible individual is covered by an HDHP and has a limited-purpose FSA then the individual can be eligible to contribute to an HSA.

When structured correctly, limited-purpose FSAs do not overlap with HDHPs. This allows for the use of a limited-purpose FSA while still being eligible for and contributing to an HSA.



**WHY IS ACCURATE
ELIGIBILITY TRACKING
IMPORTANT FOR STOP-
LOSS REIMBURSEMENT?**



THE ANSWER IS...

**Ineligible
claims may
not be
reimbursed**

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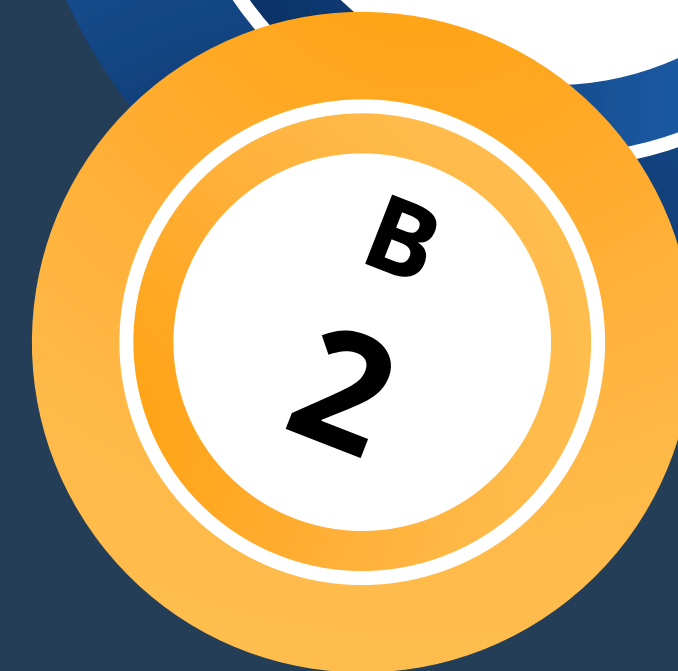
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WHY MIGHT CLAIMS NOT BE REIMBURSED?

Accurate eligibility tracking is essential for stop-loss reimbursement because only claims associated with eligible individuals are covered under the policy. If an employee or dependent is incorrectly listed as eligible when they are not, any medical claims incurred for the individual may be denied by the stop loss carrier. This means the employer could be responsible for costs they expected to be reimbursed for.

In short, inaccurate eligibility data can lead directly to unreimbursed claims and unexpected financial exposure.



WHAT IS THE ACA DEFINITION OF A FULL- TIME EMPLOYEE?



THE ANSWER IS...

**30+ hours
per week (or
130 hours
per month)**

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WHY DOES THIS MATTER?

This definition is important because it determines which employees must be offered health coverage to comply with Affordable Care Act (ACA) employer mandate requirements.

The employer mandate, or “pay or play” provision under the ACA, requires employers with 50 or more full-time equivalent employees (ALEs) to offer affordable, minimum-value health insurance to at least 95% of their full-time employees and dependents or pay a tax penalty.



**WHAT DISQUALIFIES
SOMEONE FROM HSA
CONTRIBUTIONS BESIDES
AN FSA?**



THE ANSWER IS...

**Medicare
entitlement**

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WHAT IS THE DIFFERENCE BETWEEN MEDICARE ELIGIBLE AND MEDICARE ENTITLEMENT?

The terms “eligible” and “entitled” are not synonymous under the Medicare regulations. To be entitled to Medicare, an individual must generally be both eligible and enrolled. For HSA purposes, the IRS Code states that an individual’s contribution limit becomes zero “for the first month such individual is *entitled* to benefits” under Medicare. Further clarification has provided that mere eligibility for Medicare does not make an individual ineligible to contribute to an HSA and that a Medicare-eligible individual who is not actually enrolled in Medicare Part A, Part B, Part D, or any other Medicare benefit may contribute to an HSA until the month that they are enrolled in Medicare.

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**WHAT HAPPENS IF THERE
IS NO WRITTEN SECTION
125 CAFETERIA PLAN
DOCUMENT?**



THE ANSWER IS...

**Tax
benefits
may be lost**

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WHAT IF WE DON'T HAVE A WRITTEN SECTION 125 PLAN DOCUMENT?


A written Section 125 cafeteria plan is required for employees and employers to receive tax advantages on benefit elections. Without a formal, compliant plan document in place, the IRS may not recognize these elections as qualifying under Section 125. As a result, employees could lose the ability to pay for benefits on a pre-tax basis, meaning their contributions would be treated as taxable income. At the same time, the employer could lose their tax benefits as well, since those contributions may be reclassified as taxable wages which could increase liability for payroll taxes.



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**WHAT'S ONE OF THE MOST
DANGEROUS PHRASES IN
BENEFITS
ADMINISTRATION?**



THE ANSWER IS...

**“We’ll just
make an
exception”**

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WHAT'S WRONG WITH THAT?

It can quickly undermine the consistency and compliance of a plan. Benefits must be administered according to written plan documents and applicable regulations. By making exceptions, even with good intentions, it can create inequities among employees and potentially violate the rules. Over time, repeated exceptions can expose the employer to compliance risks, discrimination issues, and even loss of plan protections. What seems like a small, one-off decision can lead to significant legal and financial consequences.



B I N G O

THANK YOU FOR PLAYING!

Up Next:

Reception

4:00 p.m. – 5:30 p.m.

Commons on Vine

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