

# Section 125 Qualifying Events

A Section 125 Cafeteria Plan must provide that participant elections are irrevocable and cannot be changed during the period of coverage, generally the plan year. However, an employer may design the plan to permit certain exceptions to the rule, known as qualifying events, which are governed by the Treasury regulations in Section 1.125. In general, if an employee requests an election change under these events, the request must be consistent with the event, and the request must be made within the time period governed by the Cafeteria Plan Document, typically 30 days (although a longer time frame may be allowed if the document provides for one).

## Health Care Reform Changes

On Sept. 18, 2014, the IRS released Notice 2014-55, which created two new, optional qualifying events. Employers wishing to adopt these new events need to amend their plan document. The IRS allowed employers to retroactively amend their plans to the first day of the plan year, as long as the amendment is adopted on or before the last day of the plan year in which the elections are allowed. A special rule allows for plan years beginning in 2014 to adopt the amendment any time on or before the last day of the plan year that began in 2015. More information about these changes is available under the “Revocation Due to Reduction in Hours of Service,” and “Revocation Due to Enrollment in a Qualified Health Plan” qualifying events below.

Qualifying Event	Description	Examples	Coverage Affected
<p><b>HIPAA Special Enrollment Rights</b></p>	<p>HIPAA requires group health plans to give special enrollment opportunities to certain employees, dependents and COBRA qualified beneficiaries.</p> <p>A “special enrollee” is allowed to enroll or change his or her existing plan option in the plan when timely requested within 30 days (or longer if plan so provides or otherwise indicated) after: a loss of eligibility for group health coverage, health insurance coverage, CHIP or Medicaid (60 days to request); becoming eligible for state premium assistance, Medicaid or CHIP subsidies (60 days to request); and the acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption.<sup>1</sup></p> <p>Special enrollment rights typically apply with respect to the employee, dependents of the employee and the spouse of the employee. In other words, existing family members who may have previously declined coverage have another opportunity to enroll (for example, in the case of a birth of a child, a spouse can be enrolled due to the birth even if not previously covered under the plan).</p> <p>Additionally, effective for plan years beginning on or after Sept. 23, 2010, health care reform provisions require that special enrollment be given to enrollees for (1) coverage for certain adult children and (2) reinstating coverage for individuals who previously exhausted a plan’s lifetime dollar limit.</p> <p>26 CFR §1.125-4(b).</p>	<p><b>Example 1:</b> An employee’s spouse has recently exhausted her 18 months of available COBRA coverage, and has not yet found other coverage. The employee may enroll the spouse as a “special enrollee” since the COBRA coverage has been exhausted. Special enrollment rights would not be applicable if the spouse simply stopped paying the COBRA premium before exhausting coverage.</p> <p><b>Example 2:</b> An employee qualifies for premium assistance from the state. The employee notifies the employer and takes advantage of a special enrollment period due to not previously participating in the coverage.</p> <p><b>Example 3:</b> An employee acquires a dependent by birth. The employee and her spouse are currently enrolled in an HMO. The employee, spouse and newly acquired dependent receive special enrollment rights and are entitled to newly enroll in or change to any benefit package under the plan (e.g., PPO, HDHP), as if they were newly eligible for coverage. Additionally, due to a special provision for birth, adoption or placement for adoption, coverage must be effective retroactively to the date of birth as long as the enrollment request is timely (within 30 days, or longer if plan so provides).</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Dependent care</li> <li>• HIPAA-excepted health FSA</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul>

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<p><b>Change in Status</b></p>	<p>Applies to change in marital status (marriage, divorce or legal separation as defined by the state), number of dependents (includes birth, adoption, placement for adoption and death), employment status, dependent satisfies or ceases to satisfy eligibility requirements and change in residence. Finally, there was a one-time optional qualifying event for non-calendar year plans that began in 2013 and ended in 2014 which allowed employees to enroll or disenroll in employer's major medical coverage in order to avoid the individual mandate penalty effective Jan. 1, 2014. This was not an ongoing qualifying event and did require employers sponsoring non-calendar year plans to adopt a plan amendment.</p> <p>26 CFR §1.125-4(c)(1)(i).</p>	<p><b>Example 1:</b> A part-time employee previously ineligible under the terms of the plan is now full-time and satisfies eligibility. The employee would be given the opportunity to enroll self, spouse or dependents. If a full-time employee is now part-time and this results in a loss of eligibility, the employee is allowed to revoke elections.</p> <p><b>Example 2:</b> An employee is terminated and rehired within 30 days. Prior elections at termination are reinstated unless another event has occurred. A termination and rehire after 30 days entitles an employee to make new elections under all benefit options under the plan.</p> <p><b>Example 3:</b> A student turns age 26 and is no longer considered a dependent under the terms of the plan. The employee may revoke elections for that dependent only. Employer also has a responsibility to ensure only eligible dependents are kept on the plan.</p> <p><b>Example 4:</b> An employee makes an irrevocable election during open enrollment for the plan year beginning Aug. 1, 2013. Just two months later, on Oct. 1, 2013, he saw an advertisement for the health insurance exchange available in his state. Since his employer decided to adopt this one-time optional qualifying event, the employee was able to make a prospective election to drop his coverage and enroll in the exchange coverage, effective Jan. 1, 2014. The employer processed this drop request effective Dec. 31, 2013.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Health FSA</li> <li>• Dependent care</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul>

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<p><b>Revocation Due to Reduction in Hours of Service</b></p>	<p>Beginning Sept. 18, 2014, a plan may permit an employee to prospectively revoke an election of coverage under a group health plan if the following conditions are met:</p> <ul style="list-style-type: none"> <li>• The employee has been reasonably expected to average at least 30 hours of service per week but there is a change in status so that the employee will be averaging fewer than 30 hours of service per week after the change, even if they are not expected to lose eligibility for the group health plan; and</li> <li>• The employee intends to enroll himself and any related individuals whose coverage will cease, after revoking coverage, in another plan that provides at least minimum essential coverage; and</li> <li>• The new coverage is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.</li> </ul> <p>The plan may rely on the reasonable representation of the employee that the employee and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage (MEC). The plan does not necessarily have to be sponsored by an employer or the same employer, but must be at least minimum essential coverage.</p> <p>Employers wishing to recognize this qualifying event may retroactively amend their plans to the first day of the plan year, as long as the amendment is adopted on or before the last day of the plan year in which the elections are allowed. A special rule allows for plan years beginning in 2014 to adopt the amendment any time on or before the last day of the plan year that begins in 2015.</p> <p>IRS Notice 2014-55.</p>	<p><b>Example 1:</b> An employee works full-time, 35 hours a week, and is enrolled in family coverage under the employer's group health plan. The employee's status changes and he is moved to a part-time status expected to work only 25 hours a week, although eligibility for the employer-sponsored group health plan is not affected. The employer offers another benefit package option at a lower cost to part-time employees working fewer than 30 hours a week and the employee wishes to revoke his current election and enroll in this option. The employer grants the employee's request to drop family coverage mid-year based on the employee's stated intent to switch to the other benefit package option, which does meet the MEC standard.</p> <p><b>Example 2:</b> A variable hour employee met the 30 hours of service requirements during the most recent measurement period to enroll in employer-sponsored coverage during a subsequent 12-month stability period. Although the employee is eligible for coverage and will remain eligible for the remainder of the stability period, the employee's hours have been reduced and he is not expected to continue to work 30 hours a week, making the cost of coverage burdensome. The employer offers a basic MEC plan option at a lower cost to part-time employees working fewer than 30 hours a week and the employee wishes to revoke his current election and enroll in this option. The employer grants the employee's request to drop coverage mid-year based on the employee's stated intent to switch to the other benefit package option, which does meet the MEC standard.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> </ul>

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<p><b>Revocation Due to Enrollment in a Qualified Health Plan (QHP)</b></p>	<p>Beginning Sept. 18, 2014, a plan may permit a participant who is eligible to enroll in Marketplace coverage (during either a special enrollment period (SEP) or annual open enrollment period) to drop employer-sponsored health coverage midyear if the participant intends to enroll in Marketplace coverage and the specific conditions described below are met:</p> <ul style="list-style-type: none"> <li>• The employee is eligible for a midyear SEP to enroll in a QHP through a Marketplace, or the employee seeks to enroll in a QHP through a Marketplace during the annual open enrollment period; and</li> <li>• The request to revoke coverage under the employer's group health plan corresponds to the intended enrollment of the employee (and any related individuals who cease coverage) through the Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.</li> </ul> <p>Employers wishing to recognize this qualifying event may retroactively amend their plans to the first day of the plan year, as long as the amendment is adopted on or before the last day of the plan year in which the elections are allowed. A special rule allows for plan years beginning in 2014 to adopt the amendment any time on or before the last day of the plan year that begins in 2015.</p> <p>IRS Notice 2014-55.</p>	<p><b>Example 1:</b> An employee is enrolled in family coverage under the employer's group health plan but during the Marketplace open enrollment intends to enroll himself and his family members in QHP coverage. The employee notifies the employer of his intent to enroll in coverage, and the employer has adopted this optional qualifying event under the terms of the plan. The employer grants the employee's request to drop family coverage mid-year based on the employee's stated intent to enroll in Marketplace coverage.</p> <p><b>Example 2:</b> An employee enrolled in employer-sponsored group coverage during the employer's open enrollment period, but has since located a cheaper individual policy and has requested to be dropped from the employer's coverage in order to buy the individual policy. Unless the individual policy is a QHP being purchased on the Marketplace, the request would be denied. If the individual policy is a QHP that the employee has purchased or intends to purchase on the Marketplace, and the employer adopted this optional qualifying event under the terms of the plan, the request may be granted.</p> <p><b>Example 3:</b> An employee initially enrolled in Marketplace coverage during the annual open enrollment period. However, the employee failed to pay premiums on a timely basis and coverage was cancelled. The employee requests to be added to the employer-sponsored group coverage mid-year due to loss of Marketplace coverage. Since this qualifying event only allows employer-sponsored group coverage to be dropped when Marketplace coverage is gained, rather than adding employer-sponsored coverage when Marketplace coverage is lost, the request should be denied.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> </ul>
<p><b>Change in Cost<sup>2</sup></b></p>	<p>A change in the cost of coverage that permits the employer to automatically increase or decrease the employee contributions.</p> <p>26 CFR §1.125-4(f)(2)(i).</p>	<p>An employer decides mid-year that they wish to adjust the amount of employer contributions provided for major medical coverage. The plan document includes a provision allowing the employer to automatically increase or decrease the employee contribution. The employer must determine if the change is significant or insignificant. Since it is determined the change is insignificant, the employer notifies the employees of the new cost of the plan and implements the adjustment in the next paycheck.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Health FSA</li> <li>• Dependent care</li> </ul>

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<b>Significant Cost Changes<sup>2</sup></b>	<p>A significant change in the cost of coverage that permits an employee to actually change elections (drop coverage, add coverage, switch plans).</p> <p>26 CFR §1.125-4(f)(2)(ii).</p>	<p><b>Example 1:</b> An employer decides mid-year that they wish to adjust the amount of employer contributions provided for major medical coverage. It is determined that the increase to employees is significant. The employees are permitted to make mid-year election changes based on this provision if provided for in the plan document.</p> <p><b>Example 2:</b> A child care provider increases its fee. An employee can increase her salary reduction mid-year to reflect the new fee.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Dependent care</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Health FSA</li> </ul>
<b>Significant Coverage Curtailment</b>	<p>A significant coverage curtailment (reduction in benefits) without a loss of coverage or a significant coverage curtailment, with loss of coverage.</p> <p>26 CFR §1.125-4(f)(3)(i) and 26 CFR §1.125-4(f)(3)(ii).</p>	<p>An entire network of hospitals no longer accepts the health insurance offered through the employer. Many participants lose their primary care physicians and specialists. The employer offers another benefit option that still includes the hospital network. The employees change their elections to avoid the coverage curtailment.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Dependent care</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Health FSA</li> </ul>
<b>Addition or Significant Improvement of Benefit Options</b>	<p>If a plan adds a new benefit package option or other coverage option, or improves an existing option, an employee may drop coverage for existing option, add coverage for new option or switch plans.</p> <p>26 CFR §1.125-4(f)(3)(iii).</p>	<p>An employer has previously provided the choice of a PPO or HMO under the major medical plans. They decide mid-year to add a High Deductible Health Plan (HDHP) with HSA as a benefit offering. Since this is an employer initiated improvement, this provision allows employees to make an election change to the HDHP and revoke the election to the PPO or HMO.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Dependent care</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Health FSA</li> </ul>
<b>Change of Coverage Under Another Employer's Plan</b>	<p>Allows for a new election or revoking a previous plan election when a change is made under another employer plan (including a plan of the same employer or of another employer) for the employee, spouse or dependent.</p> <p>26 CFR §1.125-4(f)(4).</p>	<p><b>Example 1:</b> A son's employer begins offering coverage for the first time, which provides him with major medical, dental and vision. Even though the son is still a dependent for purposes of the plan, the parent wishes to drop the son from coverage since he has other insurance. This would be permissible if the plan allows for this provision.</p> <p><b>Example 2:</b> A husband has open enrollment in December each year. A wife has open enrollment in June. The husband covers the entire family through his employer, but in June the family decides to switch to the wife's insurance. The husband is permitted to drop all coverage under this provision.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Dependent care</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Health FSA</li> </ul>

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<b>Loss of Group Coverage Under a Governmental or Educational Institution</b>	<p>Allows adding coverage under a cafeteria plan for the employee, spouse or dependent if the employee, spouse or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, which includes: state CHIP, coverage through an Indian tribe and a state risk pool.</p> <p>26 CFR §1.125-4(f)(5).</p>	<p><b>Example 1:</b> An employee has employee-only coverage under the employer plan, and her three children are covered under the state's CHIP plan. Mid-year, the employee is promoted and her new salary makes her children ineligible for the CHIP coverage. Since the plan includes this provision, the employee adds her dependents to her employer-provided coverage. A loss of coverage under a state CHIP plan may also trigger HIPAA special enrollment rights.</p> <p><b>Example 2:</b> An employee's daughter goes to college and is provided insurance through the school as part of her tuition. This does not entitle the employee to remove the daughter from employer-sponsored coverage. This change would be made at open enrollment. However, the daughter struggles in school and moves home, losing her coverage. The employee may now add the daughter back onto her employer sponsored coverage under this provision.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Dependent care</li> <li>• Health FSA</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul>
<b>Judgments, Orders or Decrees</b>	<p>Applies to a judgment, decree or order resulting from a divorce, legal separation, annulment, changes in legal custody or qualified medical child support order (QMCSO). It is important to note that ERISA requires a plan to honor qualified medical child support orders, and including this provision in the plan document allows coverage through a QMCSO to be paid pretax.</p> <p>26 CFR §1.125-4(d).</p>	<p>An employer is provided a court order which requires that the employee cover the dependent child on all available medical, dental and vision coverage available. The child does not live with the employee, and the employee is not currently enrolled in any benefit offerings through the employer, although they are eligible for it. The policies all require employees who cover dependents to be enrolled on the plan. The employer should enroll the employee and dependent on all plans, to comply with the court order.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Health FSA</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Dependent care</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul>
<b>Medicare or Medicaid Entitlement</b>	<p>If an employee, spouse or dependent becomes enrolled in coverage under Part A or Part B of Medicare, or Medicaid or loses coverage under these, a cafeteria plan may permit the employee to make an election change to increase, change or revoke coverage of that employee, spouse or dependent under the plan.</p> <p>26 CFR §1.125-4(e). This category does not include state CHIP, VA Benefits or TRICARE.</p>	<p>An employee becomes eligible for Medicare because of End Stage Renal Disease (ESRD), and requests to revoke his group medical plan election since the plan contains this provision. Later, this same employee receives a kidney transplant and exhausts his coverage from Medicare. The employee is now able to request to be re-enrolled on the group plan under this same provision.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Health FSA</li> </ul> <p>No pretax change permitted:</p> <ul style="list-style-type: none"> <li>• Dependent care</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul>

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<b>Family Medical Leave Act (FMLA)</b>	<p>An employee taking FMLA may revoke their election for medical, dental and vision and choose another option for the remaining period of leave.</p> <p>26 CFR §1.125-4(g).</p>	<p>An employee qualifies for unpaid FMLA and does not have enough paid time accrued to earn a full salary during the full 12 weeks of leave. The employee requests to revoke coverage during his leave. This is permitted under this Section 125 provision. Upon return, the employee has the right to be reinstated to the coverage in effect prior to the leave.</p>	<ul style="list-style-type: none"> <li>• Major medical</li> <li>• Major medical integrated with dental/vision</li> <li>• Stand-alone dental</li> <li>• Stand-alone vision</li> <li>• Health FSA</li> <li>• Dependent care</li> <li>• Group term life</li> <li>• AD&amp;D</li> <li>• Disability</li> </ul>

## Footnotes

<sup>1</sup> Effective April 1, 2009, if the loss of eligibility is under a Medicaid plan or the state children's health insurance program, a period of at least 60 days must be allowed to request special enrollment. 26 USC § 9801(f)(3)(A)(i).

<sup>2</sup> A change in cost may be "significant" or "insignificant." Unfortunately, no real guidance has been issued on what is "insignificant" versus "significant." The regulations only mention an example of 12.5 percent (26 CFR 1.125-4(f)(6), ex. 7), but the IRS has indicated that this should not be interpreted as a safe harbor guideline. The plan should base its determination on the plan's unique circumstances such as type of employees (minimum wage employees vs. high income), past changes (no previous changes) and type of plan changed (medical vs. vision).

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