

In This Issue

In this tenth and final issue of the McGraw Wentworth Benefit Advisor for 1998, we will review a year end checklist for group benefit programs. This review will include topics such as legislative compliance, taxable consequences of group term life insurance, W-2 filing requirements for disability payments, Medicare costs, and the 1999 indexed plan limits.

Each Benefit Advisor was designed to:

-Provide information on specific technical, tax or legislative issues affecting employee benefit plans.

-Offer analysis as to the impact that those issues have on your plans.

-Establish the framework for us to work with you in determining the action steps necessary to bring your plans into compliance.

We look forward to your comments and suggestions regarding future issues of the Benefit Advisor. You can reach us by contacting your account team or by utilizing the Feedback Forum on our interactive web site at www.mcgrawwentworth.com.

We wish you a happy and healthy new year!

1998 Year End Checklist

PRIORITIES FOR GROUP BENEFIT PROFESSIONALS

Group benefit plan sponsors have a number of reporting, disclosure and testing requirements that must be addressed each calendar year. This technical bulletin is designed to serve as a reminder of these requirements and to provide you with information regarding 1999 updates to specific benefit limitations and regulations.



GROUP TERM LIFE INSURANCE IMPUTED INCOME

Section 79 of the Internal Revenue Code requires employers to report imputed income on the value of the company-paid life insurance benefits in excess of \$50,000. Section 79 also taxes company-paid group term life insurance plans if they discriminate in favor of key employees.

If you provide company-paid life insurance over \$50,000 for any employees or if you offer a company-paid group term life plan that discriminates in favor of key

employees, you must calculate the imputed income or value of the excess coverage. The imputed income value of the life insurance needs to be included as taxable income to each affected employee's paycheck.

The calculation of imputed income for non-discriminatory plans and for non-key employees covered under discriminatory plans is based upon Table I rates. For key employees in a discriminatory plan, the calculation also requires a copy of the insurer's table of premium rates, which is used to determine the group composite rate. You will need to perform several calculations on this rate table to determine if the actual cost is greater than the Table I rates.

Please review the eighth issue of the Benefit Advisor for more information regarding Section 79 and how to calculate necessary imputed income based on your group plan's provisions.

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SHORT TERM DISABILITY W-2 FORMS

If you offer a company-paid short term disability plan, W-2's must be issued for all employees who received benefits under the plan in 1998.

Some short term disability insurance carriers and administrators will issue W-2's directly to claimants who had claims during the year. However, many carriers and administrators provide you with a quarterly or annual report including the information necessary to issue the W-2's. Check with your short term disability carrier or administrator to determine how they handle W-2 issuance. If you are responsible for issuing the W-2, make sure your payroll vendor is aware that each disability claimant will have additional compensation that will need to be included on the W-2.

1999 MEDICARE COST INFORMATION

The 1999 Medicare Part A deductible and copays and Part B premium and deductible amounts are listed below:

Medicare Part A Deductible	\$768.00
Hospital Per Day Copay 60 to 90 day stays	\$192.00
90 + day stays	\$384.00
Skilled Nursing Facility Per Day Copay (after 20 days)	\$96.00
Medicare Part B Premium	\$45.50
Medicare Part B Deductible	\$100.00

MEDICARE

FEDERAL LEGISLATIVE COMPLIANCE

You should be aware of several pieces of legislation that will require your compliance during 1999.

President Clinton signed the Women's Health and Cancer Rights Act of 1998 on October 21, 1998 as part of the \$500 billion omnibus appropriations bill. The law is commonly referred to as "Janet's Law" and employers must comply effective the first plan year beginning on or after October 21, 1998.

This legislation requires that medical plans (employer sponsored, insured or self-funded, HMO plans and individual health plans) provide specific benefits to women following a mastectomy. The required coverage is for the following services:

- Reconstruction of a surgically removed breast
- Surgery and reconstruction of the alternate breast to produce a symmetrical appearance.

- Prostheses and physical complications from all stages of the performance of a mastectomy, including lymphedemas.

In addition to coverage requirements, this law requires employ-



ers to provide every group plan participant and beneficiary with an annual notice that this coverage is available under the plan. This notice requirement applies even if the plan currently provides the benefits required by this law. The law requires that notice be provided with open enrollment materials beginning with the next employer mailing on or before January 1, 1999.

For more details, please review the ninth issue of the McGraw Wentworth Benefit Advisor.

Mental Health Parity Act – Increased Cost Exemption

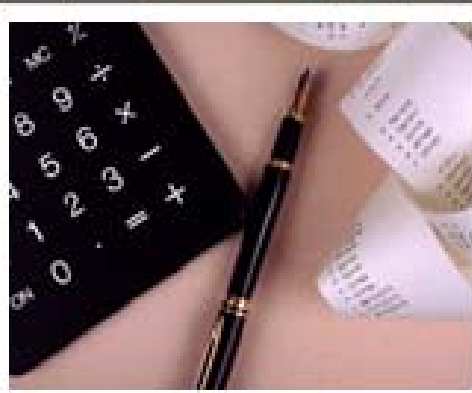
All group plans with 50+ employees were required to comply with the Mental Health Parity Act effective the first plan year on or after January 1, 1998. The Mental Health Parity Act contains an exemption for compliance if you can demonstrate that by complying with the Act your plan costs would

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increase by more than 1%.

Regulations, released by the Department of Labor last December, outlined the following guidelines for groups seeking to claim the 1 % cost exemption:

- The plan must set a test period beginning on the first day of the plan year following compliance with the Act.



- The plan must comply with the Act for at least 6 months.
- The plan must calculate the total claim cost (incurred and paid) during the test period. The estimate must include two months of run-out claims following the test period.
- The total cost of all claims must be divided by the total cost of all claims less claims that would not have been paid had the plan not complied with the Act.

If the above calculation indicates that plan costs have increased by more than 1%, the plan sponsor must follow these disclosure requirements to apply for the exemption:

- The plan must issue a notice of exemption to all participants. The notice will inform participants that the plan will claim the increased cost exemption.

- The notice must be provided to plan participants with at least 30 days advance notice.
- The plan must provide notice to the appropriate Federal Agency of the plan's intent to claim the exemption.
- The plan must make available to plan participants, if requested, documentation of the calculation showing the increased cost.

The exemption is effective through the expiration date of the Act, September 30, 2001.

Newborns' & Mothers' Protection Act

The Department of Labor has published interim regulations that change the model summary plan

description language for the Newborns' and Mothers' Health Protection Act. This change will apply to the first Summary Plan Description or Summary of Material Modification you provide to plan participants after November 9, 1998.

The amended model plan language is as follows:

"Group health plans and health insurance issuers generally may not, under Federal, law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the

BENEFIT ADVISOR

1998 ISSUE LIST

Issue	Title
Issue 3, Feb 98	Section 125 Cafeteria Plans - Audit Activity by the Internal Revenue Service
Issue 4, Mar 98	Disability Plan Management - A Look at Impact & Direction
Issue 5, Jul 98	IRS Form 5500 - Not Just For Retirement Plans
Issue 6, Aug 98	U.S. Supreme Court Decides COBRA Case
Issue 7, Oct 98	New Medicare Options - The Budget Reconciliation Act of 1997
Issue 8, Nov 98	IRC Section 79 - Tax Consequences of Group Term Life Insurance
Issue 9, Dec 98	The Women's Health and Cancer Rights Act

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mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under Federal law require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable)."

1999 INDEXED PLAN LIMITS

The table to the right reflects the 1999 indexed plan limits. The 401(k) deferral limit is unchanged for 1999. The FICA taxable wage base increases from \$68,400 in 1998 to \$72,600 in 1999.

1998 INDEXED PLAN LIMITS		
Plan Limits	1998	1999
Section 401(k) or SAR-SBP	\$10,000	\$10,000
Section 402(b) Plan	\$10,000	\$10,000
Section 408(b)(p)(2)(A)SIMPLE Plan Contributions	\$6,000	\$6,000
Section 457(b)(2) Limit	\$8,000	\$8,000
Section 415 Limit for:		
Defined Contribution Plans	\$30,000	\$30,000
Defined Benefit Plans	\$130,000	\$130,000
Highly Compensated Employees		
Section 414(q)	\$80,000	\$80,000
Section 401(a)(17) Includible Compensation	\$160,000	\$160,000
Annual Excess Distributions-Section 4980(c)(1)(b)	Repealed	Repealed
FICA Taxable Wage Base		
Social Security (Tax Rate 6.2%)	\$68,400	\$72,600
Medicare (Tax Rate 1.45%)	No Limit	No Limit

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Our technical bulletins are written and produced by the McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.



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