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GRS INSIGHT

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IRS Proposes Regulations to Provide Greater Clarity for Nonqualified Plans of Exempt Organizations

On June 22, 2016, the Internal Revenue Service ("IRS") issued proposed regulations under Section 457 of the Internal Revenue Code ("Code") regarding the taxation of compensation deferred under certain plans maintained by governmental entities and tax-exempt organizations. Specifically, the proposed regulations provide rules for determining: 1) when amounts deferred by employees of tax-exempt organizations, including governmental entities, are includible in income; 2) the amounts that are includible in income; and 3) the types of plans or arrangements that are not subject to these rules.[1]

These rules mirror many of the rules under Code Section 409A with respect to severance and substantial risk of forfeiture, while also updating the 2003 final regulations under Code Section 457 for other statutory changes in the law affecting plans subject to Code Section 457. Further, while there are many similarities in the requirements under Code Sections 457(f) and 409A, the proposed rules make it clear that Code Section 457(f) rules apply separately, and in addition to, any requirements under Code Section 409A.

Eligible/Ineligible Plans

Code Section 457 generally applies to nonqualified deferred compensation plans maintained by state or local governments and tax-exempt organizations other than a church. Entities subject to Code Section 457 are generally known as "eligible employers" and amounts deferred under an eligible deferred compensation plan under Code Section 457(b) (plus earnings) are includible in an employee's income in the year paid or otherwise made available to the employee.

If a nonqualified deferred compensation plan does not meet certain requirements under Code Section 457(b), the plan is treated as an "ineligible plan" and is subject to Code Section 457(f). Under Code Section 457(f), the present value of an amount deferred under an ineligible plan is taxable to the employee in the year the amount is no longer subject to a substantial risk of forfeiture (i.e., it is taxed at vesting).

Exemptions

Certain types of arrangements are specifically exempted from coverage under these proposed rules including:

[1] 81 Fed. Reg. 40548 (June 22, 2016).

In This Issue

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Bona Fide Severance Pay Plan

A "bona fide severance pay plan" is exempt under Code Section 457(e)(11). Generally, the definition of such plans in the proposed rules tracks the regulatory definition under Code Section 409A for exempt severance pay:

- Benefits are payable only upon involuntary severance from employment (this requirement does not apply to window programs or certain voluntary early retirement incentive plans);
- The amount payable does not exceed two times the participant's annualized compensation for the prior calendar year; and
- A written plan document requires that the entire severance amount must be paid no later than the last day of the second calendar year following the calendar year containing the date of the participant's severance from employment.

One difference from the Code Section 409A definition is that the exemption under Code Section 457 for severance pay plans does not apply the Code Section 401(a)(17) compensation limit to the amount of annualized compensation for the two-times limit. However, similar to Code Section 409A, under the proposed rules, involuntary severance from employment means an employer's unilateral decision to terminate the participant's services, including severance from employment for good reason (i.e., resulting in a material negative change in the employment relationship). This determination is based on all the facts and circumstances without regard to any characterization of the reason for the payment by the employer or participant.

Bona Fide Sick or Vacation Leave Plan

The proposed rules provide that a "bona fide sick or vacation leave plan" will be exempt if, based on the facts and circumstances, it is demonstrated that the primary purpose of the plan is to provide for paid time off from work due to sickness, vacation, or other personal reasons. Factors to be considered when making this determination include:

- whether the amount of leave provided could reasonably be expected to be used by the employee in the normal course and before the employee ceases to provide services to the employer;
- whether the plan limits the ability to exchange unused accumulated leave for cash or other benefits, including non-taxable benefits, and any applicable accrual restrictions (e.g., "use-or-lose" rules);
- the amount and frequency of any in-service distributions of cash or other benefits in exchange for accumulated and unused leave;
- whether payment of unused leave is made promptly upon severance from employment (as opposed to paid over a period of time); and
- whether the leave offered is broadly applicable or available only to a limited number of employees.

Thus, the proposed rules call into question the exempt nature of leave programs – seen most often in the government sector – which allow a participant to accumulate significant amounts of leave to be exchanged for cash or paid at retirement.

Death Benefit and Disability Plans

The proposed rules also provide clarification on the requirements for exemption for death benefit and disability plans from Code Section 457. Specifically:

- A "bona fide death benefit plan" is defined in accordance with the FICA rules[2] (i.e., a benefit is a death benefit only to the extent it is in excess of lifetime benefits).
- A "bona fide disability pay plan" pays benefits only in the event that a participant is disabled, and the definition of disabled tracks the more restrictive definition provided under Code Section 409A (i.e., unable to engage in any substantial gainful activity . . . expected to result in death or last for a continuous period of not less than 12 months).

Substantial Risk of Forfeiture

Once an amount deferred under a plan subject to Code Section 457(f) is no longer subject to a "substantial risk of forfeiture," that amount becomes taxable to the employee in that year. Generally, Code Section 457(f)(3)(B) provides that a substantial risk of forfeiture exists if an employee's rights to compensation are conditioned on the future performance of substantial future services.

The proposed rules clarify that a substantial risk of forfeiture exists only if "entitlement to the amount is conditioned on the future performance of substantial services, or upon the occurrence of a condition that is related to a purpose of the compensation if the possibility of forfeiture is substantial." This clarifies and aligns the definition with Code Section 409A, except in the context of non-compete agreements, as described on the following page.

[2] Treas. Reg. Sec. 31.3121(v)(2)-1(b)(4)(iv)(C).

Non-Compete Agreements

Generally, non-compete agreements do not create a substantial risk of forfeiture. However, if all of the following conditions are satisfied, a substantial risk of forfeiture will likely occur if an employee accepts a prohibited position:

- The right to payment is expressly conditioned upon the non-compete in a written agreement that is enforceable under applicable law;
- The employer makes reasonable efforts to verify compliance with non-competition agreements, including the one applicable to the employee; and
- The facts and circumstances, at the time the agreement becomes binding, show that the employer has a substantial and bona fide interest in preventing the employee from performing the prohibited services and the employee has a bona fide interest in, and ability to, engage in the prohibited services.

Rolling Risks of Forfeiture

An attempt to extend the period covered by a risk of forfeiture, often called a "rolling risk of forfeiture," is disregarded unless certain conditions are met. The addition or extension of a risk of forfeiture, after the legally binding right to compensation arises, must satisfy all of the following to avoid immediate taxation:

- The present value of the deferred amount must be "materially greater" than the amount the employee otherwise would have received. For this purpose, materially greater is defined as more than 125% of the present value of the prior amount.
- The employee must be required to perform substantial future services or refrain from competing for an additional period of at least two years, subject to permitted vesting on death, disability or involuntary termination. A performance goal would not satisfy this requirement.
- The addition or extension of a substantial risk of forfeiture must be made in writing before the calendar year in which services are performed in the case of initial deferrals, or ninety (90) days before the date a substantial risk of forfeiture would have lapsed absent an extension.

Determination of Present Value

In addition, another area where the proposed rules generally track the rules for Code Section 409A is in the rules for determining present value. However, present value under the proposed rules is determined as of the applicable date, as compared to the end of the employee's taxable year under Code Section 409A. A few other notable requirements discussed in the proposed rules include:

- ***Reasonable Actuarial Assumptions.*** The present value must be determined using actuarial assumptions and methods that are reasonable based on all of the facts and circumstances as of the applicable date.
- ***Treatment of Severance from Employment.*** If payment depends on severance and the employee has not terminated from employment as of the applicable date, the employer may use any date on or before the fifth anniversary of the applicable date unless unreasonable (e.g., if the employer knows the employee will terminate in 2018, the employer cannot use a later date).
- ***Account Balance Plans.*** For account balance plans with a reasonable interest rate or based on a predetermined actual investment, the present value is equal to the account balance as of that date. If an account balance plan is credited with the greater of two or more rates of return (e.g., a combination of investment and interest rate), the plan will be treated as a non-account balance plan for purposes of determining present value.
- ***Formula Amounts.*** For formula amounts, an employer must use reasonable good faith assumptions with respect to any contingencies. Any increase or decrease due to a change in facts and circumstances is treated as earnings or losses, respectively. To the extent applicable, an amount of deferred compensation may be broken into formula and non-formula amounts.
- ***Forfeiture or Other Permanent Loss.*** In the event forfeiture occurs after the applicable date, an employee is entitled to a deduction for the amount permanently forfeited. This would generally be treated as a miscellaneous itemized deduction and would not be subject to Code Section 1341 (i.e., no unrestricted right).

Not a "Deferral of Compensation"

The proposed rules provide other clarifications on what qualifies as a deferral of compensation:

- ***Short-Term Deferrals.*** A deferral of compensation under Code Section 457(f) does not occur with respect to any payment exempt from Code Section 409A under the short-term deferral exemption. Thus, a deferral from one year to a payment date on or before March 15th of the following year is not a deferral for either Code Section 457(f) or 409A.
- ***Recurring Part-Year Compensation.*** A deferral of compensation may not occur with respect to an amount that is recurring part-year compensation, as defined under Code Section 409A. Specifically, there is no deferral of compensation if the plan does not

defer payment beyond the last day of the 13th month following the first day of the service period and the amount does not exceed the annual compensation limit under Code Section 401(a)(17). This is helpful for professors and teachers who are paid on an annualized basis, though not working the entire year.

Applicability

Taxpayers may rely on these proposed rules immediately. Once adopted, the final rules will generally apply to all deferred compensation arrangements and amounts that have not been previously included in income (i.e., there is no grandfathering for prior arrangements). A public hearing on the proposed rules was scheduled for October 18, 2016.

Further Clarifications on the Downsized IRS Determination Letter Program

On June 29, 2016, the IRS issued Revenue Procedure 2016-37 to provide additional clarifications on the future of the determination letter program. As governmental plans have been hearing for a while, effective January 1, 2017, the staggered five-year determination letter remedial amendment cycles for individually designed plans will be eliminated, and effective July 21, 2015, off-cycle determination letters were no longer accepted.

For individually-designed governmental plans, review under the new program will be limited to: 1) initial plan qualification for a plan that has never filed a Form 5300 or for a plan that filed a Form 5300 but a determination letter was not issued, regardless of when the plan was adopted; 2) qualification upon plan termination (Form 5310); and 3) certain other limited circumstances to be determined from time to time by the IRS and U.S. Treasury in published guidance (this will be an annual determination and none will be permitted for 2017).

Amendments

A "Required Amendments List" will be published annually by the IRS. Generally, for individually designed plans, plan sponsors will have at least two full years after the year in which the requirement is announced to adopt a required amendment. This will give plan sponsors more time than the current period for the adoption of "interim amendments," which generally requires amendments by the end of the plan year in which the amendment is effective. The IRS does not generally intend to include an item on the Required Amendments List until guidance on the issue has been provided, including a model amendment. The IRS also announced that the "remedial amendment period" ("RAP") for disqualifying provisions that are effective on or after January 1, 2016, will generally extend to the end of the second calendar year after the calendar year the amendment is adopted or is effective, whichever is later (and the RAP will not end before December 31, 2017).

Governmental plans will have an extended period during which to adopt amendments. Specifically, the adoption deadline for interim amendments (and disqualifying provisions) is the later of: a) the regular remedial amendment period for interim amendments; or b) 90 days after the close of the third regular legislative session of the legislative body with authority to amend the plan that begins on or after the amendment's effective date. For discretionary amendments, the RAP extends to the later of: a) the regular remedial amendment period for discretionary amendments; or b) 90 days after the close of the second regular legislative session of the legislative body with authority to amend the plan that begins on or after the amendment's effective date.

Notably, because of the lack of IRS review, unless additional guidance is issued, it may be unclear to a plan sponsor as to whether a discretionary amendment (and perhaps also a required one) is in fact "disqualifying" (and there is no anti-cutback relief under the current guidance).

Operational Compliance List

In addition to plan language changes, plan sponsors must ensure their plans comply in operation with changes in qualification rules from the new rule's effective date. To assist with this compliance, the IRS will publish an "Operational Compliance List" to help sponsors identify the rules they should be following before the required amendment must be (and is) adopted.

Expiration Dates

As provided in Notice 2016-3, expiration dates on determination letters issued before January 4, 2016 are no longer operative and new letters will no longer have them. Under the new guidance, a plan sponsor may continue to rely on a determination letter with respect to plan provisions that are not amended or affected by a change in law, so long as IRS guidelines for reliance have been met (e.g., that all material facts were disclosed in the earlier review). The IRS intends to issue further guidance addressing the extent of reliance on these letters in the case of law changes or amendments to the plan. Therefore, for the vast majority of previously-reviewed provisions in an existing plan, employers can continue to rely on existing letters where the plan provisions do not change, unless Congress changes the law or the IRS comes out with a new ruling or regulation.

Pre-Approved Plans

The 6-year remedial amendment period and the existing Cumulative List continue to apply to pre-approved plans (including governmental pre-approved plans), with the same amendment deadlines. The RAP for governmental pre-approved plans will track the adoption period for individually designed governmental plans, in accordance with the type of amendment.

Application of the 6-year cycle and, in particular, the impact of employer amendments still needs to be carefully considered to avoid a loss of reliance on the plan's opinion/ advisory letter. As noted previously, there are limited opportunities to obtain a determination letter for an individually designed plan.

The guidance also provides a 6-month extension for current pre-approved defined contribution plans to file for a new opinion/advisory letter (the submission period is currently August 1, 2017- July 31, 2018, but is subject to change). Consistent with the objective to move more employers with individually designed plans to a pre-approved plan document, Notice 2016-3 also extended the deadline – from April 30, 2016 to April 30, 2017 – for an employer not currently on a pre-approved defined contribution plan document to adopt one (and to apply for a determination letter, if permitted).

IRS Provides Indirect Rollover Relief

In an effort to ease the burden on taxpayers who miss the 60-day window for an indirect rollover, the IRS recently issued guidance in Revenue Procedure 2016-47 which provides relief in certain delineated situations. Under the general rule, a taxpayer may only roll over an eligible distribution to another plan or IRA within 60 days of receiving the distribution. Prior to this new relief, a taxpayer who missed the 60-day rollover deadline was required to seek a hardship waiver in the form of a private letter ruling from the IRS (and pay a large filing fee, currently $10,000) if the taxpayer wanted to make a rollover after the expiration of such 60-day period. Effective August 24, 2016, in addition to the private letter ruling process, taxpayers may now complete a self-certification claiming eligibility for a waiver of the 60-day period.

Requirements for Relief

Revenue Procedure 2016-47 permits a taxpayer to make a written certification to a plan administrator or IRA trustee that he or she is eligible to make a rollover after the 60-day period if specified conditions are met. The taxpayer may use the model self-certification provided by the IRS, or may use a letter that is materially similar. The certification should be provided to the plan administrator or IRA trustee and a copy should be retained by the taxpayer in his or her tax records.

To claim eligibility for a waiver:

- The IRS must not have previously denied a waiver request with respect to any part of the distribution in question; and
- The contribution must be made to the receiving plan or IRA as soon as practicable after the barrier to the rollover has been removed. For this purpose, if the contribution is made within 30 days after the reason(s) listed below no longer prevent the taxpayer from making the contribution, this requirement is deemed to have been satisfied.

At least one of the following 11 valid reasons specifically identified by the IRS for the taxpayer's inability to complete a rollover within the 60-day rollover period must apply to the taxpayer:

- an error by the receiving or distributing financial institution;
- the check (if applicable) was misplaced and never cashed;
- the distribution was deposited into and remained in what the taxpayer mistakenly thought was an eligible retirement plan;
- severe damage to the taxpayer's principal residence;
- the death of a member of the taxpayer's family;
- a serious illness of the taxpayer or a member of the taxpayer's family;
- incarceration of the taxpayer;
- restrictions imposed by a foreign country;
- a postal error;
- the distribution was originally made on account of a tax levy and the levy proceeds have been returned to the taxpayer; or
- the party making the distribution delayed in providing the necessary information to complete the rollover, despite the taxpayer's reasonable efforts to obtain the information.

Effect of Certification

A plan administrator or IRA trustee who receives a self-certification satisfying the applicable conditions may rely on that certification and accept a rollover which would otherwise be outside of the 60-day window if: 1) the administrator or trustee does not have actual knowledge that would contradict the information in the certification; and 2) the rollover is otherwise a valid rollover (i.e., the certification may be relied upon only for purposes of waiving the 60-day requirement). Further, while the self-certification does not constitute a waiver by the IRS of

the 60-day requirement, a taxpayer may report the contribution as a valid rollover unless the IRS later asserts otherwise (e.g., in the course of an examination).

The IRS intends to modify Form 5498 to require an IRA trustee to indicate whether the contribution was accepted after the 60-day deadline. There is no such similar reporting requirement for rollover contributions to a qualified plan.

Going Forward

This guidance is likely to affect governmental plans in one of two key ways:

1. Governmental plans that accept rollover contributions (including as "regular" rollovers or for the purchase of permissive service credit) may want to utilize this member-friendly guidance.
2. For governmental plans that allow lump sum distributions, this guidance could allow members to correct for situations where they failed to timely roll over lump sum distributions.

Going forward, governmental plans and IRA providers should consider whether changes should be made to their rollover contribution procedures to allow for this new approach and, if so, copies of the self-certification and a notation regarding no actual knowledge to the contrary should be retained in the entity's files (along with other evidence of a valid rollover). The IRS indicates via its website that plan sponsors and IRA providers may also provide the IRS model certification letter to taxpayers who are seeking to self-certify a late rollover, available at: https://www.irs.gov/retirement-plans/accepting-late-rollover-contributions.

In the event that the IRS determines on audit that the hardship waiver is not met, the plan sponsor will need to distribute the invalid rollover contribution (and earnings thereon) as soon as reasonably practical following such determination in order to maintain the tax qualified status of the plan in accordance with Treasury Regulation Section 1.401(a)(31)-1, Q&A-14 (or for an IRA provider, treat the contribution as a regular contribution subject to an annual 6% excise tax under Code Section 4973).

HHS Notice of Benefit and Payment Parameters for 2018 Proposed Rule

Background

On September 6, 2016, the U.S. Department of Health and Human Services ("HHS") published a proposed rule for the health insurance market, titled the *HHS Notice of Benefit and Payment Parameters for 2018* ("Proposed Rule").[3] HHS publishes this rule annually to update the health insurance market reforms for the individual and group markets, health insurance Exchange standards, and premium stabilization programs, specifically the risk adjustment program. The Proposed Rule also proposes updated annual limitation on cost sharing (i.e., maximum out-of-pocket ("MOOP")) amounts for 2018. Comments on the Proposed Rule were due by October 6, 2016. The key market reform issues include:

Market Reforms

HHS proposes a number of changes that would apply to non-grandfathered health insurance issuers and group health plans.

Changing the Definition of "Plan" and "Product"

HHS proposes to change the regulatory definitions of "plan" and "product" so a plan or product is not tied to a particular issuer. The preamble to the Proposed Rule explains that HHS is proposing this change so the plan or product would be considered the same plan or product when it is offered by a different issuer in the same controlled group. HHS also proposes to clarify that if a product has been modified, transferred or replaced, the product will be considered the "same product" when it meets the uniform modification of coverage standards. In addition, HHS adds examples of product network types (e.g., HMO, PPO, indemnity) to the definition of product.

Market Withdrawal Exceptions to Guaranteed Renewability Provisions

Currently, if an issuer discontinues all coverage in a particular market, the issuer is banned from re-entering the market for five years, under federal guaranteed renewability regulations. In the Proposed Rule, HHS proposes two exceptions to the five-year market re-entry ban when an issuer discontinues all coverage in a particular market: 1) if, as part of a corporate reorganization, the issuer transfers all its products to another related issuer in the same controlled group, the products would be considered the same products (and would be subject to *renewal notice* requirements); and 2) when an issuer discontinues all products and seeks to offer new products within the same market (in this case, the issuer would be subject to product *discontinuance notice* requirements). In both situations, issuers would

[3] 81 Fed. Reg. 61456

still be subject to rate review requirements. HHS proposes that states may still consider these scenarios market withdrawals with a five-year re-entry ban.

Child Age Rating Changes

Health insurance issuers offering individual and small group coverage currently must have a single age band for all children ages 0-20. HHS has acknowledged that this may be problematic because it does not reflect the true costs of the health insurance market, and individuals experience a significant rate increase when they turn age 21 (i.e., when they are rated as adults). In this rule, HHS proposes to create multiple child age bands: one band for individuals ages 0-14, and single-year age bands for individuals ages 15-20. This change would be effective for plan or policy years beginning on or after January 1, 2018. HHS also proposes a corresponding increase in the overall child age factor. HHS asks whether these age rating factors should be implemented at one time or phased in over a three-year period.

Annual Limitation on Cost Sharing

MOOP Amounts for 2018

As is customary in this annual rule, the Proposed Rule proposes the 2018 maximum annual limitation on cost sharing – or "MOOP" – amount for both the individual and group markets. For 2018, HHS proposes that the MOOP be $7,350 for self-only coverage and $14,700 for other than self-only coverage. This proposal is a 2.8% increase from the 2017 amounts, which are $7,150 for self-only coverage and $14,300 for other than self-only coverage.

IRS Proposes Regulations on Opt-Out Payments and Affordability

On July 8, 2016, the IRS issued proposed regulations addressing how cash incentives an employer offers employees for not enrolling in the employer's health coverage ("opt-out payments") impact affordability for purposes of the premium tax credit and the individual mandate penalty provisions. These regulations focus on individuals rather than employers. However, the draft 2016 Instructions for Forms 1094-C and 1095-C, issued on August 1, 2016, direct applicable large employers to these proposed regulations for rules regarding affordability and opt-out arrangements for purposes of the employer mandate. The proposed regulations largely follow the approach the IRS outlined in Notice 2015-87 (issued on December 16, 2015), with some new rules. These rules are proposed to be effective for plan years beginning on or after January 1, 2017.

Under the proposed regulations, there are two types of opt-out arrangements:

1. **"Unconditional" opt-out arrangements:** If an employer *offers* an employee an opt-out payment that is not conditioned on the employee having other coverage, the payment increases the employee's "required contribution" (i.e., his/her cost of coverage) for purpose of the employer mandate and reporting on Form 1095-C, regardless of whether the employee enrolls in the plan or receives the opt-out payment.

   The proposed regulations provide the following transition relief:

   - Certain opt-out arrangements that were adopted on or before December 16, 2015 do not increase the employee's required contribution until the applicability date of final regulations.
   - Certain opt-out arrangements required under the terms of a collective bargaining agreement ("CBA") in effect before December 16, 2015 do not increase the employee's required contribution until the later of: 1) the beginning of the first plan year that begins following the expiration of the CBA in effect before December 16, 2015 (disregarding any extensions); or 2) the applicability date of the final regulations.

2. **"Eligible" opt-out arrangements do not increase an employee's cost of coverage:** If an employer offers an opt-out payment only to employees who: 1) decline the employer-sponsored coverage; and 2) annually provide reasonable evidence that the employee (and tax dependents) have/will have minimum essential coverage (other than individual market coverage) during the plan year or other period covered by the opt-out arrangement, the payment does not increase the employee's required contribution for purposes of the employer mandate and reporting on Form 1095-C.

Key Takeaway: Employers that have opt-out arrangements should consider whether such payments impact affordability enough to cause the coverage to be unaffordable and whether the payment/contribution structure should be redesigned.

COBRA FAQ: Notice of Coverage Options

Background

If an individual who was covered by a group health plan experiences a qualifying event, that individual may be eligible for COBRA continuation coverage. A group health plan administrator must provide a notice to each qualified beneficiary no later than 14 days after the plan receives notice of the qualifying event.[4] The notice must be written in a manner understood by the average plan participant, and, among other requirements, the notice must identify the qualifying event, describe the group plan's procedures for electing continuation coverage, and describe the continuation coverage that will be made available under the plan.[5] In an effort to notify qualified beneficiaries that they are also eligible for Marketplace coverage due to this qualifying event, plans can use a model notice published by the Department of Labor ("DOL"), which includes information about Marketplace coverage. COBRA Model Election Notice is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra.

FAQ

On June 21, 2016, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") published an FAQ to clarify that a group health plan administrator can include additional information about Marketplace coverage within, or along with, the COBRA Model Election Notice posted by DOL. FAQs about Affordable Care Act Implementation – Part 32 are available at: https://www.dol.gov/ebsa/faqs/faq-aca-32.html.

The FAQ also states that plan administrators may include other information about the Marketplaces, including: "how to obtain assistance with enrollment (including special enrollment), the availability of financial assistance, information about Marketplace websites and contact information, general information regarding particular products offered in the Marketplaces, and other information that may help qualified beneficiaries choose between COBRA and other coverage options."

The Departments encourage plan administrators to help individuals find coverage that is the most suitable for them. Therefore, plan administrators may tailor their COBRA election notices to particular groups of people (e.g., young adults aging off of their parents' plans) as long as the notices remain "easily understood by the average plan participant."

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[4] 29 CFR § 2590.606-4(b).
[5] 29 CFR § 2590.606-4(b)(4).

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