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§ 2400.8 Schedule of fees.

(a) *Policy*. The purpose of this section is to establish fair and equitable fees to permit reproduction of records for concerned individuals.

(b) *Reproduction*. (1) For reproducing any paper or micrographic record or publication, the fee is $.10 per page. No charge shall be made if the total fee authorized by this part in compliance with a request or series of related requests is less than $3.00.

(2) OSHRC shall not normally furnish more than one copy of any record.

(c) *Limitations*. No fee shall be charged to any individual for the process of retrieving, or amending records.

§ 2400.9 Exemptions.

(a) Subsections 552a (j) and (k) of title 5, United States Code, empower the Chairman to exempt systems of records meeting certain criteria from various other subsections of section 552a. With respect to systems of records so exempted, nothing in this part shall require compliance with any provisions hereof implementing any subsections of section 552a from which those systems may properly be and have been exempted.

CHAPTER XXV—PENSION AND WELFARE BENEFITS ADMINISTRATION, DEPARTMENT OF LABOR

SUBCHAPTER A—GENERAL

Part		Page
2509	Interpretive bulletins relating to the Employee Retirement Income Security Act of 1974	313

SUBCHAPTER B—DEFINITIONS AND COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

2510	Definitions of terms used in subchapters C, D, E, F, and G of this chapter	339

SUBCHAPTER C—REPORTING AND DISCLOSURE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

2520	Rules and regulations for reporting and disclosure	361

SUBCHAPTER D—MINIMUM STANDARDS FOR EMPLOYEE PENSION BENEFIT PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

2530	Rules and regulations for minimum standards for employee pension benefit plans	433

SUBCHAPTER E [RESERVED]

SUBCHAPTER F—FIDUCIARY RESPONSIBILITY UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

2550	Rules and regulations for fiduciary responsibility	474

SUBCHAPTER G—ADMINISTRATION AND ENFORCEMENT UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

2560	Rules and regulations for administration and enforcement	514
2570	Procedural regulations under the employee retirement income security act	531

Part		Page
2575	Adjustment of civil penalties under ERISA Title I	565

SUBCHAPTER H [RESERVED]

SUBCHAPTER I—TEMPORARY BONDING RULES UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

2580	Temporary bonding rules	567

SUBCHAPTER J—FIDUCIARY RESPONSIBILITY UNDER THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986

2582	Rules and regulations for fiduciary responsibility	584
2584	Rules and regulations for the allocation of fiduciary responsibility	585

SUBCHAPTER K—ADMINISTRATION AND ENFORCEMENT UNDER THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986

2589	Rules and regulations for administration and enforcement	589

SUBCHAPTER L—HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

2590	Rules and regulations for group health plan requirements	590

SUBCHAPTER A—GENERAL

PART 2509—INTERPRETIVE BULLETINS RELATING TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Sec.
2509.75–2 Interpretive bulletin relating to prohibited transactions.
2509.75–3 Interpretive bulletin relating to investments by employee benefit plans in securities of registered investment companies.
2509.75–4 Interpretive bulletin relating to indemnification of fiduciaries.
2509.75–5 Questions and answers relating to fiduciary responsibility.
2509.75–6 Interpretive bulletin relating to section 408(c)(2) of the Employee Retirement Income Security Act of 1974.
2509.75–8 Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.
2509.75–9 Interpretive bulletin relating to guidelines on independence of accountant retained by Employee Benefit Plan.
2509.75–10 Interpretive bulletin relating to the ERISA Guidelines and the Special Reliance Procedure.
2509.78–1 Interpretive bulletin relating to payments by certain employee welfare benefit plans.
2509.94–1 Interpretive bulletin relating to the fiduciary standard under ERISA in considering economically targeted investments.
2509.94–2 Interpretive bulletin relating to written statements of investment policy, including proxy voting policy or guidelines.
2509.94–3 Interpretive bulletin relating to in-kind contributions to employee benefit plans.
2509.95–1 Interpretive bulletin relating to the fiduciary standard under ERISA when selecting an annuity provider.
2509.96–1 Interpretive bulletin relating to participant investment education.
2509.99–1 Interpretive bulletin relating to payroll deduction IRAs.

AUTHORITY: 29 U.S.C. 1135. Sections 2509.75–10 and 2509.75–2 issued under 29 U.S.C. 1052, 1053, 1054. Secretary of Labor's Order No. 1–87 (52 FR 13139).

§ 2509.75–2 Interpretive bulletin relating to prohibited transactions.

On February 6, 1975, the Department of Labor issued an interpretive bulletin, ERISA IB 75–2, with respect to whether a party in interest has engaged in a prohibited transaction with an employee benefit plan where the party in interest has engaged in a transaction with a corporation or partnership (within the meaning of section 7701 of the Internal Revenue Code of 1954) in which the plan has invested.

On November 13, 1986 the Department published a final regulation dealing with the definition of ''plan assets''. See § 2510.3–101 of this title. Under that regulation, the assets of certain entities in which plans invest would include ''plan assets'' for purposes of the fiduciary responsibility provisions of the Act. Section 2510.3–101 applies only for purposes of identifying plan assets on or after the effective date of that section, however, and § 2510.3–101 does not apply to plan investments in certain entities that qualify for the transitional relief provided for in paragraph (k) of that section. The principles discussed in paragraph (a) of this Interpretive Bulletin continue to be applicable for purposes of identifying assets of a plan for periods prior to the effective date of § 2510.3–101 and for investments that are subject to the transitional rule in § 2510.3–101(k). Paragraphs (b) and (c) of this Interpretive Bulletin, however, relate to matters outside the scope of § 2510.3–101, and nothing in that section affects the continuing application of the principles discussed in those parts.

(a) *Principles applicable to plan investments to which § 2510.3–101 does not apply*. Generally, investment by a plan in securities (within the meaning of section 3(20) of the Employee Retirement Income Security Act of 1974) of a corporation or partnership will not, solely by reason of such investment, be considered to be an investment in the underlying assets of such corporation or partnership so as to make such assets of the entity ''plan assets'' and thereby make a subsequent transaction between the party in interest and the corporation or partnership a prohibited transaction under section 406 of the Act.

For example, where a plan acquires a security of a corporation or a limited partnership interest in a partnership, a subsequent lease or sale of property between such corporation or partnership and a party in interest will not be a prohibited transaction solely by reason of the plan's investment in the corporation or partnership.

This general proposition, as applied to corporations and partnerships, is consistent with section 401(b)(1) of the Act, relating to plan investments in investment companies registered under the Investment Company Act of 1940. Under section 401(b)(1), an investment by a plan in securities of such an investment company may be made without causing, solely by reason of such investment,

any of the assets of the investment company to be considered to be assets of the plan.

(b) [Reserved]

(c) *Applications of the fiduciary responsibility rules.* The preceding paragraphs do not mean that an investment of plan assets in a security of a corporation or partnership may not be a prohibited transaction. For example, section 406(a)(1)(D) prohibits the direct or indirect transfer to, or use by or for the benefit of, a party in interest of any assets of the plan and section 406(b)(1) prohibits a fiduciary from dealing with the assets of the plan in his own interest or for his own account.

Thus, for example, if there is an arrangement under which a plan invests in, or retains its investment in, an investment company and as part of the arrangement it is expected that the investment company will purchase securities from a party in interest, such arrangement is a prohibited transaction.

Similarly, the purchase by a plan of an insurance policy pursuant to an arrangement under which it is expected that the insurance company will make a loan to a party in interest is a prohibited transaction.

Moreover, notwithstanding the foregoing, if a transaction between a party in interest and a plan would be a prohibited transaction, then such a transaction between a party in interest and such corporation or partnership will ordinarily be a prohibited transaction if the plan may, by itself, require the corporation or partnership to engage in such transaction.

Similarly, if a transaction between a party in interest and a plan would be a prohibited transaction, then such a transaction between a party in interest and such corporation or partnership will ordinarily be a prohibited transaction if such party in interest, together with one or more persons who are parties in interest by reason of such persons' relationship (within the meaning of section 3(14)(E) through (I)) to such party in interest may, with the aid of the plan but without the aid of any other persons, require the corporation or partnership to engage in such a transaction. However, the preceding sentence does not apply if the parties in interest engaging in the transaction, together with one or more persons who are parties in interest by reason of such persons' relationship (within the meaning of section 3(14)(E) through (I)) to such party in interest, may, by themselves, require the corporation or partnership to engage in the transaction.

Further, the Department of Labor emphasizes that it would consider a fiduciary who makes or retains an investment in a corporation or partnership for the purpose of avoiding the application of the fiduciary responsibility provisions of the Act to be in contravention of the provisions of section 404(a) of the Act.

[51 FR 41280, Nov. 13, 1986, as amended at 61 FR 33849, July 1, 1996]

§ 2509.75–3 Interpretive bulletin relating to investments by employee benefit plans in securities of registered investment companies.

On March 12, 1975, the Department of Labor issued an interpretive bulletin, ERISA IB 75–3, with regard to its interpretation of section 3(21)(B) of the Employee Retirement Income Security Act of 1974. That section provides that an investment by an employee benefit plan in securities issued by an investment company registered under the Investment Company Act of 1940 shall not by itself cause the investment company, its investment adviser or principal underwriter to be deemed to be a fiduciary or party in interest ''except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter.''

The Department of Labor interprets this section as an elaboration of the principle set forth in section 401(b)(1) of the Act and ERISA IB 75–2 (issued February 6, 1975) that the assets of an investment company shall not be deemed to be assets of a plan solely by reason of an investment by such plan in the shares of such investment company. Consistent with this principle, the Department of Labor interprets this section to mean that a person who is connected with an investment company, such as the investment company itself, its investment adviser or its principal underwriter, is not to be deemed to be a fiduciary of or party in interest with respect to a plan solely because the plan has invested in the investment company's shares.

This principle applies, for example, to a plan covering employees of an investment adviser to an investment company where the plan invests in the securities of the investment company. In such a case the investment company or its principal underwriter is not to be deemed to be a fiduciary of or party in interest with respect to the plan solely because of such investment.

On the other hand, the exception clause in section 3(21) emphasizes that if an investment company, its investment adviser or its principal underwriter is a fiduciary or party in interest for a reason other than the investment in the securities of the investment company, such a person remains a party in interest or fiduciary. Thus, in the preceding example, since an employer is a party in interest, the investment adviser remains a

party in interest with respect to a plan covering its employees.

The Department of Labor emphasized that an investment adviser, principal underwriter or investment company which is a fiduciary by virtue of section 3(21)(A) of the Act is subject to the fiduciary responsibility provisions of part 4 of title I of the Act, including those relating to fiduciary duties under section 404.

[40 FR 31599, July 28, 1975. Redesignated at 41 FR 1906, Jan. 13, 1976]

§ 2509.75–4 Interpretive bulletin relating to indemnification of fiduciaries.

On June 4, 1975, the Department of Labor issued an interpretive bulletin, ERISA IB 75–4, announcing the Department's interpretation of section 410(a) of the Employee Retirement Income Security Act of 1974, insofar as that section relates to indemnification of fiduciaries. Section 410(a) states, in relevant part, that ''any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy.''

The Department of Labor interprets this section to permit indemnification agreements which do not relieve a fiduciary of responsibility or liability under part 4 of title I. Indemnification provisions which leave the fiduciary fully responsible and liable, but merely permit another party to satisfy any liability incurred by the fiduciary in the same manner as insurance purchased under section 410(b)(3), are therefore not void under section 410(a).

Examples of such indemnification provisions are:

(1) Indemnification of a plan fiduciary by (a) an employer, any of whose employees are covered by the plan, or an affiliate (as defined in section 407(d)(7) of the Act) of such employer, or (b) an employee organization, any of whose members are covered by the plan; and

(2) Indemnification by a plan fiduciary of the fiduciary's employees who actually perform the fiduciary services.

The Department of Labor interprets section 410(a) as rendering void any arrangement for indemnification of a fiduciary of an employee benefit plan by the plan. Such an arrangement would have the same result as an exculpatory clause, in that it would, in effect, relieve the fiduciary of responsibility and liability to the plan by abrogating the plan's right to recovery from the fiduciary for breaches of fiduciary obligations.

While indemnification arrangements do not contravene the provisions of section 410(a), parties entering into an indemnification agreement should consider whether the agreement complies with the other provisions of part 4 of title I of the Act and with other applicable laws.

[40 FR 31599, July 28, 1975. Redesignated at 41 FR 1906, Jan. 13, 1976]

§ 2509.75–5 Questions and answers relating to fiduciary responsibility.

On June 25, 1975, the Department of Labor issued an interpretive bulletin, ERISA IB 75–5, containing questions and answers relating to certain aspects of the recently enacted Employee Retirement Income Security Act of 1974 (the ''Act'').

Pending the issuance of regulations or other guidelines, persons may rely on the answers to these questions in order to resolve the issues that are specifically considered. No inferences should be drawn regarding issues not raised which may be suggested by a particular question and answer or as to why certain questions, and not others, are included. Furthermore, in applying the questions and answers, the effect of subsequent legislation, regulations, court decisions, and interpretative bulletins must be considered. To the extent that plans utilize or rely on these answers and the requirements of regulations subsequently adopted vary from the answers relied on, such plans may have to be amended.

An index of the questions and answers, relating them to the appropriate sections of the Act, is also provided.

INDEX

KEY TO QUESTION PREFIXES

D—Refers to Definitions.
FR—Refers to Fiduciary Responsibility.

Section No.	Question No.
3(21)	D–1.
3(38)	FR–6, FR–7.
402(a)	FR–1, FR–2, FR–3.
402(b)(1)	FR–4, FR–5.
402(c)(3)	FR–6, FR–7.
404(a)	FR–10.
405(a)(3)	FR–10.
405(b)(1)(A)	FR–10.
406(a)	FR–9.
409(a)	FR–10.
412(a)	FR–8, FR–9.

D–1 Q: Is an attorney, accountant, actuary or consultant who renders legal, accounting, actuarial or consulting services to an employee benefit plan (other than an investment adviser to the plan) a fiduciary to the plan solely by virtue of the rendering of such services, absent a showing that such consultant (a) exercises discretionary authority or discretionary control respecting the management of the plan, (b) exercises authority or

control respecting management or disposition of the plan's assets, (c) renders investment advice for a fee, direct or indirect, with respect to the assets of the plan, or has any authority or responsibility to do so, or (d) has any discretionary authority or discretionary responsibility in the administration of the plan?

A: No. However, while attorneys, accountants, actuaries and consultants performing their usual professional functions will ordinarily not be considered fiduciaries, if the factual situation in a particular case falls within one of the categories described in clauses (a) through (d) of this question, such persons would be considered to be fiduciaries within the meaning of section 3(21) of the Act. The Internal Revenue Service notes that such persons would also be considered to be fiduciaries within the meaning of section 4975(e)(3) of the Internal Revenue Code of 1954.

FR–1 Q: If an instrument establishing an employee benefit plan provides that the plan committee shall control and manage the operation and administration of the plan and specifies who shall constitute the plan committee (either by position or by naming individuals to the committee), does such provision adequately satisfy the requirement in section 402(a) that a ''named fiduciary'' be provided for in a plan instrument?

A: Yes. While the better practice would be to state explicitly that the plan committee is the ''named fiduciary'' for purposes of the Act, clear identification of one or more persons, by name or title, combined with a statement that such person or persons have authority to control and manage the operation and administration of the plan, satisfies the ''named fiduciary'' requirement of section 402(a). The purpose of this requirement is to enable employees and other interested persons to ascertain who is responsible for operating the plan. The instrument in the above example, which provides that ''the plan committee shall control and manage the operation and administration of the plan'', and specifies, by name or position, who shall constitute the committee, fulfills this requirement.

FR–2 Q: In a union negotiated employee benefit plan, the instrument establishing the plan provides that a joint board on which employees and employers are equally represented shall control and manage the operation and administration of the plan. Does this provision adequately satisfy the requirement in section 402(a) that a ''named fiduciary'' be provided for in a plan instrument?

A: Yes, for the reasons stated in response to question FR–1. The joint board is clearly identified as the entity which has authority to control and manage the operation and administration of the plan, and the persons designated to be members of such joint board would be named fiduciaries under section 402(a).

FR–3 Q: May an employee benefit plan covering employees of a corporation designate the corporation as the ''named fiduciary'' for purposes of section 402(a)(1) of the Act?

A: Yes, it may. Section 402(a)(2) of the Act states that a ''named fiduciary'' is a fiduciary either named in the plan instrument or designated according to a procedure set forth in the plan instrument. A fiduciary is a ''person'' falling within the definition of fiduciary set forth in section 3(21)(A) of the Act. A ''person'' may be a corporation under the definition of person contained in section 3(9) of the Act. While such designation satisfies the requirement of enabling employees and other interested persons to ascertain the person or persons responsible for operating the plan, a plan instrument which designates a corporation as ''named fiduciary'' should provide for designation by the corporation of specified individuals or other persons to carry out specified fiduciary responsibilities under the plan, in accordance with section 405(c)(1)(B) of the Act.

FR–4 Q: A defined benefit pension plan's procedure for establishing and carrying out a funding policy provides that the plan's trustees shall, at a meeting duly called for the purpose, establish a funding policy and method which satisfies the requirements of part 3 of title I of the Act, and shall meet annually at a stated time of the year to review such funding policy and method. It further provides that all actions taken with respect to such funding policy and method and the reasons therefor shall be recorded in the minutes of the trustees' meetings. Does this procedure comply with section 402(b)(1) of the Act?

A: Yes. The above procedure specifies who is to establish the funding policy and method for the plan, and provides for a written record of the actions taken with respect to such funding policy and method, including the reasons for such actions. The purpose of the funding policy requirement set forth in section 402(b)(1) is to enable plan participants and beneficiaries to ascertain that the plan has a funding policy that meets the requirements of part 3 of title I of the Act. The procedure set forth above meets that requirement.

FR–5 Q: Must a welfare plan in which the benefits are paid out of the general assets of the employer have a procedure for establishing and carrying out a funding policy set forth in the plan instrument?

A: No. Section 402(b)(1) requires that the plan provide for such a procedure ''consistent with the objectives of the plan'' and requirements of title I of the Act. In situations in which a plan is unfunded and title I of the Act does not require the plan to be funded, there is no need to provide for such a procedure. If the welfare plan were funded,

a procedure consistent with the objectives of the plan would have to be established.

FR–6 Q: May an investment adviser which is neither a bank nor an insurance company, and which is not registered under the Investment Advisers Act of 1940 in reliance upon an exemption from registration provided in that Act, be appointed an investment manager under section 402(c)(3) of the Act?

A: No. The only persons who may be appointed an investment manager under section 402(c)(3) of the Act are persons who meet the requirements of section 3(38) of the Act—namely, banks (as defined in the Investment Advisers Act of 1940), insurance companies qualified under the laws of more than one state to manage, acquire and dispose of plan assets, or persons registered as investment advisers under the Investment Advisers Act of 1940.

FR–7 Q: May an investment adviser that has a registration application pending under the Investment Advisers Act of 1940 function as an investment manager under the Act prior to the effective date of registration under the Investment Advisers Act?

A: No, for the reasons stated in the answer to FR–6 above.

FR–8 Q: Under the temporary bonding regulation set forth in 29 CFR 2550.412–1, must a person who renders investment advice to a plan for a fee or other compensation, direct or indirect, but who does not exercise or have the right to exercise discretionary authority with respect to the assets of the plan, be bonded solely by reason of the provision of such investment advice?

A: No. A person who renders investment advice, but who does not exercise or have the right to exercise discretionary authority with respect to plan assets, is not required to be bonded solely by reason of the provision of such investment advice. Such a person is not considered to be ''handling'' funds within the meaning of the temporary bonding regulation set forth in 29 CFR 2550.412–1, which incorporates by reference 29 CFR 464.7. For purposes of the temporary bonding regulation, only those fiduciaries who handle funds must be bonded. If, in addition to the rendering of investment advice, such person performs any additional function which constitutes the handling of plan funds under 29 CFR 464.7, the person would have to be bonded.

FR–9 Q: May an employee benefit plan purchase a bond covering plan officials?

A: Yes. The bonding requirement, which applies, with certain exceptions, to every plan official under section 412(a) of the Act, is for the protection of the plan and does not benefit any plan official or relieve any plan official of any obligation to the plan. The purchase of such bond by a plan will not, therefore, be considered to be in contravention of sections 406(a) or (b) of the Act.

FR–10 Q: An employee benefit plan is considering the construction of a building to house the administration of the plan. One trustee has proposed that the building be constructed on a cost plus basis by a particular contractor without competitive bidding. When the trustee was questioned by another trustee as to the basis of choice of the contractor, the impact of the building on the plan's administrative costs, whether a cost plus contract would yield a better price to the plan than a fixed price basis, and why a negotiated contract would be better than letting the contract for competitive bidding, no satisfactory answers were provided. Several of the trustees have argued that letting such a contract would be a violation of their general fiduciary responsibilities. Despite their arguments, a majority of the trustees appear to be ready to vote to construct the building as proposed. What should the minority trustees do to protect themselves from liability under section 409(a) of the Act and section 405(b)(1)(A) of the Act?

A: Here, where a majority of trustees appear ready to take action which would clearly be contrary to the prudence requirement of section 404(a)(1)(B) of the Act, it is incumbent on the minority trustees to take all reasonable and legal steps to prevent the action. Such steps might include preparations to obtain an injunction from a Federal District court under section 502(a)(3) of the Act, to notify the Labor Department, or to publicize the vote if the decision is to proceed as proposed. If, having taken all reasonable and legal steps to prevent the imprudent action, the minority trustees have not succeeded, they will not incur liability for the action of the majority. Mere resignation, however, without taking steps to prevent the imprudent action, will not suffice to avoid liability for the minority trustees once they have knowledge that the imprudent action is under consideration.

More generally, trustees should take great care to document adequately all meetings where actions are taken with respect to management and control of fplan assets. Written minutes of all actions taken should be kept describing the action taken, and stating how each trustee voted on each matter. If, as in the case above, trustees object to a proposed action on the grounds of possible violation of the fiduciary responsibility provisions of the Act, the trustees so objecting should insist that their objections and the responses to such objections be included in the record of the meeting. It should be noted that, where a trustee believes that a cotrustee has already committed a breach, resignation by the trustee as a protest against such breach will not generally be considered sufficient to discharge the trustee's positive duty under section 405(a)(3) to

make reasonable efforts under the circumstances to remedy the breach.

[40 FR 31599, July 28, 1975. Redesignated at 41 FR 1906, Jan. 13, 1976]

§ 2509.75–6 Interpretive bulletin relating to section 408(c)(2) of the Employee Retirement Income Security Act of 1974.

The Department of Labor today announced guidelines for determining when a party in interest with respect to an employee benefit plan may receive an advance for expenses to be incurred on behalf of the plan without engaging in a transaction prohibited by section 406 of the Employee Retirement Income Security Act of 1974. That section prohibits, among other things, any lending of money from a plan to a party in interest, or transfer to, or use by or for the benefit of, a party in interest of any assets of the plan, as well as any act whereby a fiduciary deals with the assets of a plan in his own interest or for his own account.

However, section 408(c)(2) of the Act provides that nothing in section 406 of the Act shall be construed to prohibit the reimbursement by a plan of expenses properly and actually incurred by a fiduciary in the performance of his duties with the plan. Questions have arisen under section 408(c)(2) of the Act as to whether a plan may reimburse a party in interest in the performance of his duties with the plan and as to whether a plan might make an advance to a fiduciary or other party in interest for expenses to be incurred in the future.

The Department of Labor views the relevant provisions of section 408(c)(2) as clarifying the scope of section 406 so as to permit reimbursement of fiduciaries for expenses incurred in the performance of their duties with a plan. Similarly, consistent with section 408(c)(2), section 406 is construed to permit the reimbursement by the plan of expenses properly and actually incurred by a party in interest in the performance of his duties with the plan.

If a plan makes an advance to a fiduciary or other party in interest to cover expenses to be properly and actually incurred by such person in the performance of his duties with the plan, a prohibited transaction within the meaning of section 406 shall not occur when the plan makes the advance if—

(a) The amount of such advance is reasonable with respect to the amount of the expense which is likely to be properly and actually incurred in the immediate future (such as during the next month), and

(b) The party in interest accounts to the plan at the end of the period covered by the advance for the expenses actually incurred (whether computed on the basis of actual expenses incurred or on the basis of actual transportation costs plus a reasonable per diem allowance, where appropriate).

It should be noted, however, that despite the reasonableness of the amount of the advance and of the expenses underlying it, the question of whether incurring such expenses was prudent, and thus whether the advance was for reasonable expenses, is to be judged pursuant to section 404 of the Act (relating to fiduciary responsibilities).

[40 FR 31755, July 29, 1975. Redesignated at 41 FR 1906, Jan. 13, 1976]

§ 2509.75–8 Questions and answers relating to fiduciary responsibility under the Employee Retirement Income Security Act of 1974.

The Department of Labor today issued questions and answers relating to certain aspects of fiduciary responsibility under the Act, thereby supplementing ERISA IB 75–5 (29 CFR 2555.75–5) which was issued on June 24, 1975, and published in the FEDERAL REGISTER on July 28, 1975 (40 FR 31598).

Pending the issuance of regulations or other guidelines, persons may rely on the answers to these questions in order to resolve the issues that are specifically considered. No inferences should be drawn regarding issues not raised which may be suggested by a particular question and answer or as to why certain questions, and not others, are included. Furthermore, in applying the questions and answers, the effect of subsequent legislation, regulations, court decisions, and interpretive bulletins must be considered. To the extent that plans utilize or rely on these answers and the requirements of regulations subsequently adopted vary from the answers relied on, such plans may have to be amended.

An index of the questions and answers, relating them to the appropriate sections of the Act, is also provided.

INDEX

Key to question prefixes: D—refers to definitions; FR—refers to fiduciary responsibility.

Section No.	Question No.
3(21)(A)	D–2, D–3, D–4, D–5.
3(38)	FR–15.
402(c)(1)	FR–12.
402(c)(2)	FR–15.
402(c)(3)	FR–15.
403(a)(2)	FR–15.
404(a)(1)(B)	FR–11, FR–17.
405(a)	FR–13, FR–14, FR–16.
405(c)(1)	FR–12, FR–15.
405(c)(2)	D–4, FR–13, FR–14, FR–16.
412	D–2.

NOTE: Questions D–2, D–3, D–4, and D–5 relate to not only section 3(21)(A) of title I of

the Act, but also section 4975(e)(3) of the Internal Revenue Code (section 2003 of the Act). The Internal Revenue Service has indicated its concurrence with the answers to these questions.

D–2 Q: Are persons who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform the following administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons, fiduciaries with respect to the plan:

(1) Application of rules determining eligibility for participation or benefits;

(2) Calculation of services and compensation credits for benefits;

(3) Preparation of employee communications material;

(4) Maintenance of participants' service and employment records;

(5) Preparation of reports required by government agencies;

(6) Calculation of benefits;

(7) Orientation of new participants and advising participants of their rights and options under the plan;

(8) Collection of contributions and application of contributions as provided in the plan;

(9) Preparation of reports concerning participants' benefits;

(10) Processing of claims; and

(11) Making recommendations to others for decisions with respect to plan administration?

A: No. Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan, and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so.

However, although such a person may not be a plan fiduciary, he may be subject to the bonding requirements contained in section 412 of the Act if he handles funds or other property of the plan within the meaning of applicable regulations.

The Internal Revenue Service notes that such persons would not be considered plan fiduciaries within the meaning of section 4975(e)(3) of the Internal Revenue Code of 1954.

D–3 Q: Does a person automatically become a fiduciary with respect to a plan by reason of holding certain positions in the administration of such plan?

A: Some offices or positions of an employee benefit plan by their very nature require persons who hold them to perform one or more of the functions described in section 3(21)(A) of the Act. For example, a plan administrator or a trustee of a plan must, be the very nature of his position, have ''discretionary authority or discretionary responsibility in the administration'' of the plan within the meaning of section 3(21)(A)(iii) of the Act. Persons who hold such positions will therefore be fiduciaries.

Other offices and positions should be examined to determine whether they involve the performance of any of the functions described in section 3(21)(A) of the Act. For example, a plan might designate as a ''benefit supervisor'' a plan employee whose sole function is to calculate the amount of benefits to which each plan participant is entitled in accordance with a mathematical formula contained in the written instrument pursuant to which the plan is maintained. The benefit supervisor, after calculating the benefits, would then inform the plan administrator of the results of his calculations, and the plan administrator would authorize the payment of benefits to a particular plan participant. The benefit supervisor does not perform any of the functions described in section 3(21)(A) of the Act and is not, therefore, a plan fiduciary. However, the plan might designate as a ''benefit supervisor'' a plan employee who has the final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits. Under these circumstances, the benefit supervisor would be a fiduciary within the meaning of section 3(21)(A) of the Act.

The Internal Revenue Service notes that it would reach the same answer to this question under section 4975(e)(3) of the Internal Revenue Code of 1954.

D–4 Q: In the case of a plan established and maintained by an employer, are members of the board of directors of the employer fiduciaries with respect to the plan?

A: Members of the board of directors of an employer which maintains an employee benefit plan will be fiduciaries only to the extent that they have responsibility for the functions described in section 3(21)(A) of the Act. For example, the board of directors may be responsible for the selection and retention of plan fiduciaries. In such a case, members of the board of directors exercise ''discretionary authority or discretionary control respecting management of such plan'' and are, therefore, fiduciaries with respect to the plan. However, their responsibility, and, consequently, their liability, is limited to the selection and retention of fiduciaries (apart from co-fiduciary liability arising under circumstances described in section 405(a) of the

Act). In addition, if the directors are made named fiduciaries of the plan, their liability may be limited pursuant to a procedure provided for in the plan instrument for the allocation of fiduciary responsibilities among named fiduciaries or for the designation of persons other than named fiduciaries to carry out fiduciary responsibilities, as provided in section 405(c)(2).

The Internal Revenue Service notes that it would reach the same answer to this question under section 4975(e)(3) of the Internal Revenue Code of 1954.

D–5 Q: Is an officer or employee of an employer or employee organization which sponsors an employee benefit plan a fiduciary with respect to the plan solely by reason of holding such office or employment if he or she performs none of the functions described in section 3(21)(A) of the Act?

A: No, for the reasons stated in response to question D–2.

The Internal Revenue Service notes that it would reach the same answer to this question under section 4975(e)(3) of the Internal Revenue Code of 1954.

FR–11 Q: In discharging fiduciary responsibilities, may a fiduciary with respect to a plan rely on information, data, statistics or analyses provided by other persons who perform purely ministerial functions for such plan, such as those persons described in D–2 above?

A: A plan fiduciary may rely on information, data, statistics or analyses furnished by persons performing ministerial functions for the plan, provided that he has exercised prudence in the selection and retention of such persons. The plan fiduciary will be deemed to have acted prudently in such selection and retention if, in the exercise of ordinary care in such situation, he has no reason to doubt the competence, integrity or responsibility of such persons.

FR–12 Q: How many fiduciaries must an employee benefit plan have?

A: There is no required number of fiduciaries that a plan must have. Each plan must, of course, have at least one named fiduciary who serves as plan administrator and, if plan assets are held in trust, the plan must have at least one trustee. If these requirements are met, there is no limit on the number of fiduciaries a plan may have. A plan may have as few or as many fiduciaries as are necessary for its operation and administration. Under section 402(c)(1) of the Act, if the plan so provides, any person or group of persons may serve in more than one fiduciary capacity, including serving both as trustee and administrator. Conversely, fiduciary responsibilities not involving management and control of plan assets may, under section 405(c)(1) of the Act, be allocated among named fiduciaries and named fiduciaries may designate persons other than named fiduciaries to carry out such fiduciary responsibilities, if the plan instrument expressly provides procedures for such allocation or designation.

FR–13 Q: If the named fiduciaries of an employee benefit plan allocate their fiduciary responsibilities among themselves in accordance with a procedure set forth in the plan for the allocation of responsibilities for operation and administration of the plan, to what extent will a named fiduciary be relieved of liability for acts and omissions of other named fiduciaries in carrying out fiduciary responsibilities allocated to them?

A: If named fiduciaries of a plan allocate responsibilities in accordance with a procedure for such allocation set forth in the plan, a named fiduciary will not be liable for acts and omissions of other named fiduciaries in carrying out fiduciary responsibilities which have been allocated to them, except as provided in section 405(a) of the Act, relating to the general rules of co-fiduciary responsibility, and section 405(c)(2)(A) of the Act, relating in relevant part to standards for establishment and implementation of allocation procedures.

However, if the instrument under which the plan is maintained does not provide for a procedure for the allocation of fiduciary responsibilities among named fiduciaries, any allocation which the named fiduciaries may make among themselves will be ineffective to relieve a named fiduciary from responsibility or liability for the performance of fiduciary responsibilities allocated to other named fiduciaries.

FR–14 Q: If the named fiduciaries of an employee benefit plan designate a person who is not a named fiduciary to carry out fiduciary responsibilities, to what extent will the named fiduciaries be relieved of liability for the acts and omissions of such person in the performance of his duties?

A: If the instrument under which the plan is maintained provides for a procedure under which a named fiduciary may designate persons who are not named fiduciaries to carry out fiduciary responsibilities, named fiduciaries of the plan will not be liable for acts and omissions of a person who is not a named fiduciary in carrying out the fiduciary responsibilities which such person has been designated to carry out, except as provided in section 405(a) of the Act, relating to the general rules of co-fiduciary liability, and section 405(c)(2)(A) of the Act, relating in relevant part to the designation of persons to carry out fiduciary responsibilities.

However, if the instrument under which the plan is maintained does not provide for a procedure for the designation of persons who are not named fiduciaries to carry out fiduciary responsibilities, then any such designation which the named fiduciaries may make will not relieve the named fiduciaries from responsibility or liability for the acts and omissions of the persons so designated.

FR–15 Q: May a named fiduciary delegate responsibility for management and control of plan assets to anyone other than a person who is an investment manager as defined in section 3(38) of the Act so as to be relieved of liability for the acts and omissions of the person to whom such responsibility is delegated?

A: No. Section 405(c)(1) does not allow named fiduciaries to delegate to others authority or discretion to manage or control plan assets. However, under the terms of sections 403(a)(2) and 402(c)(3) of the Act, such authority and discretion may be delegated to persons who are investment managers as defined in section 3(38) of the Act. Further, under section 402(c)(2) of the Act, if the plan so provides, a named fiduciary may employ other persons to render advice to the named fiduciary to assist the named fiduciary in carrying out his investment responsibilities under the plan.

FR–16 Q: Is a fiduciary who is not a named fiduciary with respect to an employee benefit plan personally liable for all phases of the management and administration of the plan?

A: A fiduciary with respect to the plan who is not a named fiduciary is a fiduciary only to the extent that he or she performs one or more of the functions described in section 3(21)(A) of the Act. The personal liability of a fiduciary who is not a named fiduciary is generally limited to the fiduciary functions, which he or she performs with respect to the plan. With respect to the extent of liability of a named fiduciary of a plan where duties are properly allocated among named fiduciaries or where named fiduciaries properly designate other persons to carry out certain fiduciary duties, see question FR–13 and FR–14.

In addition, any fiduciary may become liable for breaches of fiduciary responsibility committed by another fiduciary of the same plan under circumstances giving rise to cofiduciary liability, as provided in section 405(a) of the Act.

FR–17 Q: What are the ongoing responsibilities of a fiduciary who has appointed trustees or other fiduciaries with respect to these appointments?

A: At reasonable intervals the performance of trustees and other fiduciaries should be reviewed by the appointing fiduciary in such manner as may be reasonably expected to ensure that their performance has been in compliance with the terms of the plan and statutory standards, and satisfies the needs of the plan. No single procedure will be appropriate in all cases; the procedure adopted may vary in accordance with the nature of the plan and other facts and circumstances relevant to the choice of the procedure.

[40 FR 47491, Oct. 9, 1975. Redesignated at 41 FR 1906, Jan. 13, 1976]

§ 2509.75–9 Interpretive bulletin relating to guidelines on independence of accountant retained by Employee Benefit Plan.

The Department of Labor today announced guidelines for determining when a qualified public accountant is independent for purposes of auditing and rendering an opinion on the financial information required to be included in the annual report filed with the Department.

Section 103(a)(3)(A) requires that the accountant retained by an employee benefit plan be ''independent'' for purposes of examining plan financial information and rendering an opinion on the financial statements and schedules required to be contained in the annual report.

Under the authority of section 103(a)(3)(A) the Department of Labor will not recognize any person as an independent qualified public accountant who is in fact not independent with respect to the employee benefit plan upon which that accountant renders an opinion in the annual report filed with the Department of Labor. For example, an accountant will not be considered independent with respect to a plan if:

(1) During the period of professional engagement to examine the financial statements being reported, at the date of the opinion, or during the period covered by the financial statements, the accountant or his or her firm or a member thereof had, or was committed to acquire, any direct financial interest or any material indirect financial interest in such plan, or the plan sponsor, as that term is defined in section 3(16)(B) of the Act.

(2) During the period of professional engagement to examine the financial statements being reported, at the date of the opinion, or during the period covered by the financial statements, the accountant, his or her firm or a member thereof was connected as a promoter, underwriter, investment advisor, voting trustee, director, officer, or employee of the plan or plan sponsor except that a firm will not be deemed not independent in regard to a particular plan if a former officer or employee of such plan or plan sponsor is employed by the firm and such individual has completely disassociated himself from the plan or plan sponsor and does not participate in auditing financial statements of the plan covering any period of his or her employment by the plan or plan sponsor. For the purpose of this bulletin the term ''member'' means all partners or shareholder employees in the firm and all professional employees participating in the audit or located in an office of the firm participating in a significant portion of the audit;

(3) An accountant or a member of an accounting firm maintains financial records for the employee benefit plan.

However, an independent, qualified public accountant may permissably engage in or have members of his or her firm engage in certain activities which will not have the effect of removing recognition of his or her independence. For example, (1) an accountant will not fail to be recognized as independent if at or during the period of his or her professional engagement with the employee benefit plan the accountant or his or her firm is retained or engaged on a professional basis by the plan sponsor, as that term is defined in section 3(16)(B) of the Act. However, to retain recognition of independence under such circumstances the accountant must not violate the prohibitions against recognition of independence established under paragraphs (1), (2) or (3) of this interpretive bulletin; (2) the rendering of services by an actuary associated with an accountant or accounting firm shall not impair the accountant's or accounting firm's independence. However, it should be noted that the rendering of services to a plan by an actuary and accountant employed by the same firm may constitute a prohibited transaction under section 406(a)(1)(C) of the Act. The rendering of such multiple services to a plan by a firm will be the subject of a later interpretive bulletin that will be issued by the Department of Labor.

In determining whether an accountant or accounting firm is not, in fact, independent with respect to a particular plan, the Department of Labor will give appropriate consideration to all relevant circumstances, including evidence bearing on all relationships between the accountant or accounting firm and that of the plan sponsor or any affiliate thereof, and will not confine itself to the relationships existing in connection with the filing of annual reports with the Department of Labor.

Further interpretive bulletins may be issued by the Department of Labor concerning the question of independence of an accountant retained by an employee benefit plan.

[40 FR 53998, Nov. 20, 1975, as amended at 40 FR 59728, Dec. 30, 1975. Redesignated at 41 FR 1906, Jan. 13, 1976]

§ 2509.75–10 Interpretive bulletin relating to the ERISA Guidelines and the Special Reliance Procedure.

On November 5, 1975, the Department of Labor (the ''Department'') and the Internal Revenue Service (the ''Service'') announced the publication of a compendium of authoritative rules (hereinafter referred to as the ''ERISA Guidelines'') relating to ERISA requirements. *See* T.I.R. No. 1415 (November 5, 1975) issued by the Service. These rules were published in recognition of the need to provide an immediate and complete set of interim guidelines to facilitate (1) adoption of new employee pension benefit plans (hereinafter referred to as ''plans''), and (2) prompt amendment of existing plans, in conformance with the applicable requirements of the Employee Retirement Income Security Act of 1974 (''ERISA'') pending the issuance of final regulations or other rules. These rules govern the application of (1) the qualification requirements of the Internal Revenue Code of 1954 (the ''Code'') added or amended by ERISA, and (2) the requirements of the provisions of parts 2 and 3 of title I of ERISA paralleling such qualification requirements (both such sets of requirements hereinafter referred to collectively as the ''new qualification requirements'').

The ERISA Guidelines incorporate by reference the documents relating to the new qualification requirements heretofore published by the Department and by the Service as temporary or proposed regulations, revenue rulings, revenue procedures, questions and answers, technical information releases, and other issuances. The ERISA Guidelines also incorporate additional documents published on November 5, 1975, or to be published forthwith, which are necessary to complete the interim guidelines relating to the new qualification requirements. See the schedule set forth below for a complete list and brief description of the documents comprising the ERISA Guidelines.

The Department and the Service emphasized that the ERISA Guidelines constitute the entire set of interim rules of the Department and the Service for satisfying the new qualification requirements, and thus provide authoritative guidance in respect of the new statutory requirements bearing on qualification. These rules are applicable to individually designed plans and to multiemployer (or other multiple employer) plans, and may be relied upon until amended or supplemented by final regulations or other rules. Moreover, the Department and the Service announced that any provisions of final regulations or other rules which amend or supplement the rules contained in the ERISA Guidelines will generally be prospective only, from the date of publication. Further, in the case of employee plan provisions adopted or amended before the date of such publication which satisfy the ERISA Guidelines, such final regulations or other rules will generally be made effective for plan years commencing after such date, except in unusual circumstances.

The Service further announced that the ERISA Guidelines incorporate the procedures that will enable employers to obtain determination letters as to the qualification of pension, annuity, profit sharing, stock bonus and bond purchase plans which satisfy the requirements of sections 401(a), 403(a) and 405(a) of the Code, as amended by ERISA. The Service also pointed out that

the ERISA Guidelines will enable sponsors of master and prototype plans (whether newly established or amended) to obtain opinion letters as to the acceptability of the form of such plans, and further, that employers who establish plans designed to meet the requirements of section 301(d) of the Tax Reduction Act of 1975 (relating to employee stock ownership plans) will be able to obtain determination letters as to the acceptability of such plans (whether or not such plans are intended to be qualified).

To facilitate further the adoption of new plans and the prompt amendment of existing plans in conformance with the new qualification requirements, the Service announced on November 5, 1975, the adoption of a special procedure (hereinafter referred to as the ''Special Reliance Procedure'') pursuant to which the adoption, on or before May 30, 1976, of new plans and amendments of existing plans may be effectuated with full reliance upon the rules which comprise the ERISA Guidelines and without regard to any amendment or supplementation of such rules before such date. Therefore, except in unusual circumstances (described in Technical Information Release No. 1416 (November 5, 1975)), plans which comply with the Special Reliance Procedure shall generally be considered by the Service as satisfying the qualification requirements of the Code added or amended by ERISA for plan years commencing on or before December 31, 1976, to which such requirements are applicable, notwithstanding the date when final regulations or other rules hereafter published which amend or supplement the rules comprising the ERISA Guidelines may otherwise be made effective. Reference is hereby made to Technical Information Release No. 1416 (November 5, 1975) for a description of the Special Reliance Procedure.

The Department announced that plans which comply with the Special Reliance Procedure will be considered by the Department as satisfying the requirements of the provisions of parts 2 and 3 of title I of ERISA which parallel the qualification requirements of the Code added or amended by ERISA to the same extent as such plans are considered by the Service as satisfying, in accordance with the terms of the Special Reliance Procedure, such qualification requirements.

The availability of the Special Reliance Procedure will substantially diminish the occasions for plans to avail themselves of the right to satisfy, for tax purposes, the qualification requirements of the Code (added or amended by ERISA) by retroactive amendments adopted during or after the close of a plan year, in accordance with section 401(b) of the Code and the temporary regulations thereunder. The Department pointed out that no explicit parallel provision to section 401(b) of the Code is contained in title I of ERISA. Nevertheless, to the extent retroactive amendments to a plan are made to satisfy the requirements of parts 2 and 3 of title I of ERISA which parallel the qualification requirements of the Code added or amended by ERISA, the Department noted that such plan will be in compliance with such requirements if such an amendment designed to satisfy such requirements (1) is adopted by the end of the plan year to which such requirements are applicable, and (2) is made effective for all purposes for such entire plan year.

The schedule of documents comprising the ERISA Guidelines follows.

ERISA GUIDELINES—SCHEDULE OF DOCUMENTS

Publication date 1975	Document	Subject	Code and ERISA sections
Jan. 8	TIR 1334	Questions and answers relating to defined contribution plans subject to ERISA.	410, 411, et al.
Apr. 21	40 FR 17576	Notice of proposed rulemaking: Qualification (and other aspects) of HR–10 plans.	401(c), 401(d), 401(e), 46, 50A, 72, 404(e), 901, and 1379.
June 4	T.D. 7358	Temporary regulations: Notification of interested parties.	7476.
July 14	T.D. 7367	Temporary regulations: Notice of determination of qualification.	7476.
Sept. 8	40 FR 41654	Department of Labor—Minimum standards for hours of service, years of service, and breaks in service relating to participation, vesting, and accrual of benefits.	401(a)(3)(B), 411(a)(5)(C), and ERISA secs. 202, 203, and 204.
Sept. 17	TIR 1403	Questions and answers relating mainly to defined benefit plans subject to ERISA (addition to TIR 1334).	410, 411, et al.
Sept. 18	40 FR 43034	Notice of proposed rulemaking: Definitions of multi-employer plan and plan administrator.	414(f) and (g).

ERISA GUIDELINES—SCHEDULE OF DOCUMENTS—Continued

Publication date 1975	Document	Subject	Code and ERISA sections
Sept. 29	T.D. 7377	Temporary regulations: Certain retroactive amendments of employee plans.	401(b).
Oct. 3	T.D. 7379	Temporary regulations: Qualified joint and survivor annuities.	401(a)(11).
	T.D. 7380	Temporary regulations: Minimum participation standards.	410.
Oct. 8	T.D. 7381	Temporary regulations: Commencement of benefits.	401(a)(14).
Oct. 15	T.D. 7382	Temporary regulations: Requirement that benefits under a qualified plan are not decreased on account of certain social security increases.	401(a)(15).
Oct. 16	T.D. 7383	Temporary regulations: Nonbank trustees of pension and profit sharing trusts benefiting owner-employees.	401(d)(1).
	40 FR 48517	Notice of proposed rulemaking: Certain custodial accounts.	401(f).
Oct. 30	TIR 1408	Questions and answers relating to mergers, consolidations, etc.	401(a)(12) and 414(1).
Nov. 3	Rev. Rul. 75–480, 1975–44 IRB.	Updating of Rev. Rul. 71–446 to reflect changes mandated by ERISA.	401(a)(5).
	Rev. Rul. 75–481, 1975–44 IRB.	Guidelines for determining whether contributions or benefits under plan satisfy the limitations of sec. 415 of the code.	401(a)(16) and 415.
	TIR 1411, Rev. Proc. 75–49, 1975–48 IRB.	Vesting and discrimination	401(a)(4) and 411(d)(1).
Nov. 4	TIR 1413	Questions and answers relating to employee stock ownership plans.	401, 4975, and sec. 301(d) of the Tax Reduction Act of 1975.
Nov. 5	T.D. 7387	Temporary regulations on minimum vesting standards.	411.
	T.D. 7388	Controlled groups, businesses under common control, etc.	414(b) and (c).
(1)	TIR	Nonforfeiture of employee derived accrued benefit upon death.	411(a)(1).
(1)		Department of Labor—Interpretive bulletin: Definition of seasonal industries.	410(a)(3)(B), 411(a)(5)(C), and ERISA secs. 202(a)(3)(C), 203(b)(2)(C).
Nov. 7	40 FR 52008	Department of Labor—additional requirements applicable to definition of multiemployer plan.	414(f) and ERISA sec. 3(37).
(1)		Department of Labor—suspension of benefits upon reemployment of retiree.	411(a)(3)(B) and ERISA sec. 203(a)(3)(A).
Dec. 3	TIR 1422	Assignment or alienation of plan benefits.	401(a)(13).
Dec. 9	TIR 1424, Rev. Proc. 76–1, 1976–1 IRB..	Vesting and discrimination	401(a)(4) and 411(d)(1).
(1)	TIR, Rev. Rul	Appropriate conversion factor	411(c)(2)(B)(ii).

[1] To be published forthwith.

[41 FR 3289, Jan. 22, 1976]

§ 2509.78–1 Interpretive bulletin relating to payments by certain employee welfare benefit plans.

The Department of Labor today announced its interpretation of certain provisions of part 4 of title I of the Employee Retirement Income Security Act of 1974 (ERISA), as those sections apply to a payment by multiple employer vacation plans of a sum of money to which a participant of beneficiary of the plan is entitled to a party other than the participant or beneficiary.[1]

Section 402(b)(4) of ERISA requires every employee benefit plan to specify the basis on which payments are made to and from the plan.

Section 403(c)(1) of ERISA generally requires the assets of an employee benefit plan to be held for the exclusive purpose of providing benefits to participants in the plan and their beneficiaries[2] and defraying reasonable expenses of administering the plan. Similarly, section 404(a)(1)(A) requires a plan fiduciary to discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries of the plan and for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the plan. Section 404(a)(1)(D) further requires the fiduciary to act in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of title I of ERISA.

In addition, section 406(a) of ERISA specifically prohibits a fiduciary with respect to a plan from causing the plan to engage in a transaction if he knows or should know that such transaction constitutes, *inter alia,* a direct or indirect: furnishing of goods, services or facilities between the plan and a party in interest (section 406(a)(1)(C)); or transfer to, or use by or for the benefit of, a party in interest of any assets of the plan (section 406(a)(1)(D)). Section 406(b)(2) of ERISA prohibits a plan fiduciary from acting in any transaction involving the plan on behalf of a party, or representing a party, whose interests are adverse to the interests of the plan or of its participants or beneficiaries.

In this regard, however, Prohibited Transaction Exemptions 76–1, Part C, (41 FR 12740, March 26, 1976) and 77–10 (42 FR 33918, July 1, 1977) exempt from the prohibitions of section 406(a) and 406(b)(2), respectively, the provision of administrative services by a multiple employer plan if specified conditions are met. These conditions are: (a) the plan receives reasonable compensation for the provision of the services (for purposes of the exemption, ''reasonable compensation'' need not include a profit which would ordinarily have been received in an arm's length transaction, but must be sufficient to reimburse the plan for its costs); (b) the arrangement allows any multiple employer plan which is a party to the transaction to terminate the relationship on a reasonably short notice under the circumstances; and (c) the plan complies with certain recordkeeping requirements. It should be noted that plans not subject to Prohibited Transaction Exemptions 76–1 and 77–10—i.e., plans that are not multiple employer plans—cannot rely upon these exemptions.

A payment by a vacation plan of all or any portion of benefits to which a plan participant or beneficiary is entitled to a party other than the participant or beneficiary will comply with the above-mentioned sections of ERISA if the arrangement pursuant to which payments are made does not constitute a prohibited transaction under ERISA and:

(1) The plan documents expressly state that benefits payable under the plan to a participant or beneficiary may, at the direction of the participant or beneficiary, be paid to a third party rather than to the participant or beneficiary;

(2) The participant or beneficiary directs in writing that the plan trustee(s) shall pay a named third party all or a specified portion of the sum of money which would otherwise be paid under the plan to him or her; and

(3) A payment is made to a third party only when or after the money would otherwise be payable to the plan participant or beneficiary.

In the case of a multiple employer plan (as defined in Prohibited Transaction Exemption 76–1, Part C, Section III), if the arrangement to make payments to a third party is a prohibited transaction under ERISA, the arrangement will comply with the above-mentioned sections of ERISA if the conditions of Prohibited Transaction Exemptions 76–1, Part C, and 77–10 and the above three paragraphs are met. In this regard, it is the view of the Department that the mere payment of money to which a participant or beneficiary is entitled, at the direction of the participant or beneficiary, to a third party who is a party in interest would not constitute a transfer of plan assets prohibited under section 406(a)(1)(D). It is also the view of the Department that if a trustee or

[1] Multiple employer vacation plans generally consist of trust funds to which employers are obligated to make contributions pursuant to collective bargaining agreements. Benefits are generally paid at specified intervals (usually annually or semi-annually) and such benefits are neither contingent upon the occurrence of a specified event nor restricted to use for a specified purpose when paid to the participant.

[2] Section 403 (c) and (d) provide certain exceptions to this requirement, not here relevant.

other fudiciary of a plan, in addition to his duties with respect to the plan, serves in a decisionmaking capacity with another party, the mere fact that the fiduciary effects payments to such party of money to which a participant is entitled at the direction of the participant and in accordance with specific provisions of governing plan documents and instruments, does not amount to a prohibited transaction under section 406(b)(2).

It should be noted that the interpretation set forth herein deals solely with the application of the provisions of title I of ERISA to the arrangements described herein. It does not deal with the application of any other statute to such arrangements. Specifically, no opinion is expressed herein as to the application of section 302 of the Labor Management Relations Act, 1947 or the Internal Revenue Code of 1954 (particularly the provisions of section 501(c)(9) of the Code).

[43 FR 58565, Dec. 15, 1978]

§ 2509.94–1 Interpretive bulletin relating to the fiduciary standard under ERISA in considering economically targeted investments.

This Interpretive Bulletin sets forth the Department of Labor's interpretation of sections 403 and 404 of the Employee Retirement Income Security Act of 1974 (ERISA), as applied to employee benefit plan investments in ''economically targeted investments'' (ETIs), that is, investments selected for the economic benefits they create apart from their investment return to the employee benefit plan. Sections 403 and 404, in part, require that a fiduciary of a plan act prudently, and to diversify plan investments so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so. In addition, these sections require that a fiduciary act solely in the interest of the plan's participants and beneficiaries and for the exclusive purpose of providing benefits to their participants and beneficiaries. The Department has construed the requirements that a fiduciary act solely in the interest of, and for the exclusive purpose of providing benefits to, participants and beneficiaries as prohibiting a fiduciary from subordinating the interests of participants and beneficiaries in their retirement income to unrelated objectives.

With regard to investing plan assets, the Department has issued a regulation, at 29 CFR 2550.404a–1, interpreting the prudence requirements of ERISA as they apply to the investment duties of fiduciaries of employee benefit plans. The regulation provides that the prudence requirements of section 404(a)(1)(B) are satisfied if (1) the fiduciary making an investment or engaging in an investment course of action has given appropriate consideration to those facts and circumstances that, given the scope of the fiduciary's investment duties, the fiduciary knows or should know are relevant, and (2) the fiduciary acts accordingly. This includes giving appropriate consideration to the role that the investment or investment course of action plays (in terms of such factors as diversification, liquidity and risk/return characteristics) with respect to that portion of the plan's investment portfolio within the scope of the fiduciary's responsibility.

Other facts and circumstances relevant to an investment or investment course of action would, in the view of the Department, include consideration of the expected return on alternative investments with similar risks available to the plan. It follows that, because every investment necessarily causes a plan to forgo other investment opportunities, an investment will not be prudent if it would be expected to provide a plan with a lower rate of return than available alternative investments with commensurate degrees of risk or is riskier than alternative available investments with commensurate rates of return.

The fiduciary standards applicable to ETIs are no different than the standards applicable to plan investments generally. Therefore, if the above requirements are met, the selection of an ETI, or the engaging in an investment course of action intended to result in the selection of ETIs, will not violate section 404(a)(1)(A) and (B) and the exclusive purpose requirements of section 403.

[59 FR 32607, June 23, 1994]

§ 2509.94–2 Interpretive bulletin relating to written statements of investment policy, including proxy voting policy or guidelines.

This interpretive bulletin sets forth the Department of Labor's (the Department) interpretation of sections 402, 403 and 404 of the Employee Retirement Income Security Act of 1974 (ERISA) as those sections apply to voting of proxies on securities held in employee benefit plan investment portfolios and the maintenance of and compliance with statements of investment policy, including proxy voting policy. In addition, this interpretive bulletin provides guidance on the appropriateness under ERISA of active monitoring of corporate management by plan fiduciaries.

(1) Proxy Voting

The fiduciary act of managing plan assets that are shares of corporate stock includes the voting of proxies appurtenant to those shares of stock. As a result, the responsibility for voting proxies lies exclusively with the plan trustee except to the extent that either (1) the trustee is subject to the directions of a named fiduciary pursuant to

ERISA § 403(a)(1); or (2) the power to manage, acquire or dispose of the relevant assets has been delegated by a named fiduciary to one or more investment managers pursuant to ERISA § 403(a)(2). Where the authority to manage plan assets has been delegated to an investment manager pursuant to § 403(a)(2), no person other than the investment manager has authority to vote proxies appurtenant to such plan assets except to the extent that the named fiduciary has reserved to itself (or to another named fiduciary so authorized by the plan document) the right to direct a plan trustee regarding the voting of proxies. In this regard, a named fiduciary, in delegating investment management authority to an investment manager, could reserve to itself the right to direct a trustee with respect to the voting of all proxies or reserve to itself the right to direct a trustee as to the voting of only those proxies relating to specified assets or issues.

If the plan document or investment management agreement provides that the investment manager is not required to vote proxies, but does not expressly preclude the investment manager from voting proxies, the investment manager would have exclusive responsibility for voting proxies. Moreover, an investment manager would not be relieved of its own fiduciary responsibilities by following directions of some other person regarding the voting of proxies, or by delegating such responsibility to another person. If, however, the plan document or the investment management contract expressly precludes the investment manager from voting proxies, the responsibility for voting proxies would lie exclusively with the trustee. The trustee, however, consistent with the requirements of ERISA § 403(a)(1), may be subject to the directions of a named fiduciary if the plan so provides.

The fiduciary duties described at ERISA § 404(a)(1)(A) and (B), require that, in voting proxies, the responsible fiduciary consider those factors that may affect the value of the plan's investment and not subordinate the interests of the participants and beneficiaries in their retirement income to unrelated objectives. These duties also require that the named fiduciary appointing an investment manager periodically monitor the activities of the investment manager with respect to the management of plan assets, including decisions made and actions taken by the investment manager with regard to proxy voting decisions. The named fiduciary must carry out this responsibility solely in the interest of the participants and beneficiaries and without regard to its relationship to the plan sponsor.

It is the view of the Department that compliance with the duty to monitor necessitates proper documentation of the activities that are subject to monitoring. Thus, the investment manager or other responsible fiduciary would be required to maintain accurate records as to proxy voting. Moreover, if the named fiduciary is to be able to carry out its responsibilities under ERISA § 404(a) in determining whether the investment manager is fulfilling its fiduciary obligations in investing plans assets in a manner that justifies the continuation of the management appointment, the proxy voting records must enable the named fiduciary to review not only the investment manager's voting procedure with respect to plan-owned stock, but also to review the actions taken in individual proxy voting situations.

The fiduciary obligations of prudence and loyalty to plan participants and beneficiaries require the responsible fiduciary to vote proxies on issues that may affect the value of the plan's investment. Although the same principles apply for proxies appurtenant to shares of foreign corporations, the Department recognizes that in voting such proxies, plans may, in some cases, incur additional costs. Thus, a fiduciary should consider whether the plan's vote, either by itself or together with the votes of other shareholders, is expected to have an effect on the value of the plan's investment that will outweigh the cost of voting. Moreover, a fiduciary, in deciding whether to purchase shares of a foreign corporation, should consider whether the difficulty and expense in voting the shares is reflected in their market price.

(2) STATEMENTS OF INVESTMENT POLICY

The maintenance by an employee benefit plan of a statement of investment policy designed to further the purposes of the plan and its funding policy is consistent with the fiduciary obligations set forth in ERISA section 404(a)(1)(A) and (B). Since the fiduciary act of managing plan assets that are shares of corporate stock includes the voting of proxies appurtenant to those shares of stock, a statement of proxy voting policy would be an important part of any comprehensive statement of investment policy. For purposes of this document, the term ''statement of investment policy'' means a written statement that provides the fiduciaries who are responsible for plan investments with guidelines or general instructions concerning various types or categories of investment management decisions, which may include proxy voting decisions. A statement of investment policy is distinguished from directions as to the purchase or sale of a specific investment at a specific time or as to voting specific plan proxies.

In plans where investment management responsibility is delegated to one or more investment managers appointed by the named

fiduciary pursuant to ERISA § 402(c)(3), inherent in the authority to appoint an investment manager, the named fiduciary responsible for appointment of investment managers has the authority to condition the appointment on acceptance of a statement of investment policy. Thus, such a named fiduciary may expressly require, as a condition of the investment management agreement, that an investment manager comply with the terms of a statement of investment policy which sets forth guidelines concerning investments and investment courses of action which the investment manager is authorized or is not authorized to make. Such investment policy may include a policy or guidelines on the voting of proxies on shares of stock for which the investment manager is responsible. In the absence of such an express requirement to comply with an investment policy, the authority to manage the plan assets placed under the control of the investment manager would lie exclusively with the investment manager. Although a trustee may be subject to the directions of a named fiduciary pursuant to ERISA § 403(a)(1), an investment manager who has authority to make investment decisions, including proxy voting decisions, would never be relieved of its fiduciary responsibility if it followed directions as to specific investment decisions from the named fiduciary or any other person.

Statements of investment policy issued by a named fiduciary authorized to appoint investment managers would be part of the ''documents and instruments governing the plan'' within the meaning of ERISA § 404(a)(1)(D). An investment manager to whom such investment policy applies would be required to comply with such policy, pursuant to ERISA § 404(a)(1)(D) insofar as the policy directives or guidelines are consistent with titles I and IV of ERISA. Therefore, if, for example, compliance with the guidelines in a given instance would be imprudent, then the investment manager's failure to follow the guidelines would not violate ERISA § 404(a)(1)(D). Moreover, ERISA § 404(a)(1)(D) does not shield the investment manager from liability for imprudent actions taken in compliance with a statement of investment policy.

The plan document or trust agreement may expressly provide a statement of investment policy to guide the trustee or may authorize a named fiduciary to issue a statement of investment policy applicable to a trustee. Where a plan trustee is subject to an investment policy, the trustee's duty to comply with such investment policy would also be analyzed under ERISA § 404(a)(1)(D). Thus, the trustee would be required to comply with the statement of investment policy unless, for example, it would be imprudent to do so in a given instance.

Maintenance of a statement of investment policy by a named fiduciary does not relieve the named fiduciary of its obligations under ERISA § 404(a) with respect to the appointment and monitoring of an investment manager or trustee. In this regard, the named fiduciary appointing an investment manager must periodically monitor the investment manager's activities with respect to management of the plan assets. Moreover, compliance with ERISA § 404(a)(1)(B) would require maintenance of proper documentation of the activities of the investment manager and of the named fiduciary of the plan in monitoring the activities of the investment manager. In addition, in the view of the Department, a named fiduciary's determination of the terms of a statement of investment policy is an exercise of fiduciary responsibility and, as such, statements may need to take into account factors such as the plan's funding policy and its liquidity needs as well as issues of prudence, diversification and other fiduciary requirements of ERISA.

An investment manager of a pooled investment vehicle that holds assets of more than one employee benefit plan may be subject to a proxy voting policy of one plan that conflicts with the proxy voting policy of another plan. Compliance with ERISA § 404(a)(1)(D) would require such investment manager to reconcile, insofar as possible, the conflicting policies (assuming compliance with each policy would be consistent with ERISA § 404(a)(1)(D)) and, if necessary and to the extent permitted by applicable law, vote the relevant proxies to reflect such policies in proportion to each plan's interest in the pooled investment vehicle. If, however, the investment manager determines that compliance with conflicting voting policies would violate ERISA § 404(a)(1)(D) in a particular instance, for example, by being imprudent or not solely in the interest of plan participants, the investment manager would be required to ignore the voting policy that would violate ERISA § 404(a)(1)(D) in that instance. Such an investment manager may, however, require participating investors to accept the investment manager's own investment policy statement, including any statement of proxy voting policy, before they are allowed to invest. As with investment policies originating from named fiduciaries, a policy initiated by an investment manager and adopted by the participating plans would be regarded as an instrument governing the participating plans, and the investment manager's compliance with such a policy would be governed by ERISA § 404(a)(1)(D).

(3) SHAREHOLDER ACTIVISM

An investment policy that contemplates activities intended to monitor or influence the management of corporations in which

the plan owns stock is consistent with a fiduciary's obligations under ERISA where the responsible fiduciary concludes that there is a reasonable expectation that such monitoring or communication with management, by the plan alone or together with other shareholders, is likely to enhance the value of the plan's investment in the corporation, after taking into account the costs involved. Such a reasonable expectation may exist in various circumstances, for example, where plan investments in corporate stock are held as long-term investments or where a plan may not be able to easily dispose such an investment. Active monitoring and communication activities would generally concern such issues as the independence and expertise of candidates for the corporation's board of directors and assuring that the board has sufficient information to carry out its responsibility to monitor management. Other issues may include such matters as consideration of the appropriateness of executive compensation, the corporation's policy regarding mergers and acquisitions, the extent of debt financing and capitalization, the nature of long-term business plans, the corporation's investment in training to develop its work force, other workplace practices and financial and non-financial measures of corporate performance. Active monitoring and communication may be carried out through a variety of methods including by means of correspondence and meetings with corporate management as well as by exercising the legal rights of a shareholder.

[59 FR 38863, July 29, 1994]

§ 2509.94–3 Interpretive bulletin relating to in-kind contributions to employee benefit plans.

(a) *General.* This bulletin sets forth the views of the Department of Labor (the Department) concerning in-kind contributions (*i.e.,* contributions of property other than cash) in satisfaction of an obligation to contribute to an employee benefit plan to which part 4 of title I of the Employee Retirement Income Security Act of 1974 (ERISA) or a plan to which section 4975 of the Internal Revenue Code (the Code) applies. (For purposes of this document the term ''plan'' shall refer to either or both types of such entities as appropriate). Section 406(a)(1)(A) of ERISA provides that a fiduciary with respect to a plan shall not cause the plan to engage in a transaction if the fiduciary knows or should know that the transaction constitutes a direct or indirect sale or exchange of any property between a plan and a ''party in interest'' as defined in section 3(14) of ERISA. The Code imposes a two-tier excise tax under section 4975(c)(1)(A) an any direct or indirect sale or exchange of any property between a plan and a ''disqualified person'' as defined in section 4975(e)(2) of the Code. An employer or employee organization that maintains a plan is included within the definitions of ''party in interest'' and ''disqualified person.''[1]

In *Commissioner of Internal Revenue* v. *Keystone Consolidated Industries, Inc.*, ____ U.S. ____, 113 S. Ct. 2006 (1993), the Supreme Court held that an employer's contribution of unencumbered real property to a tax-qualified defined benefit pension plan was a sale or exchange prohibited under section 4975 of the Code where the stated fair market value of the property was credited against the employer's obligation to the defined benefit pension plan. The parties stipulated that the property was contributed to the plan free of encumbrances and the stated fair market value of the property was not challenged. 113 S. Ct. at 2009. In reaching its holding the Court construed section 4975(f)(3) of the Code (and therefore section 406(c) of ERISA), regarding transfers of encumbered property, not as a limitation but rather as extending the reach of section 4975(c)(1)(A) of the Code (and thus section 406(a)(1)(A) of ERISA) to include contributions of encumbered property that do not satisfy funding obligations. *Id.* at 2013. Accordingly, the Court concluded that the contribution of unencumbered property was prohibited under section 4975(c)(1)(A) of the Code (and thus section 406(a)(1)(A) of ERISA) as ''at least both an indirect type of sale and a form of exchange, since the property is exchanged for diminution of the employer's funding obligation.'' 113 S. Ct. at 2012.

(b) *Defined benefit plans.* Consistent with the reasoning of the Supreme Court in *Keystone,* because an employer's or plan sponsor's in-kind contribution to a defined benefit pension plan is credited to the plan's funding standard account it would constitute a transfer to reduce an obligation of the sponsor or employer to the plan. Therefore, in the absence of an applicable exemption, such a contribution would be prohibited under section 406(a)(1)(A) of ERISA and section 4975(c)(1)(A) of the Code. Such an in-kind contribution would constitute a prohibited transaction even if the value of the contribution is in excess of the sponsor's or employer's funding obligation for the plan year

[1] Under Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978), the authority of the Secretary of the Treasury to issue rulings under the prohibited transactions provisions of section 4975 of the Code has been transferred, with certain exceptions not here relevant, to the Secretary of Labor. Except with respect to the types of plans covered, the prohibited transaction provisions of section 406 of ERISA generally parallel the prohibited transaction of provisions of section 4975 of the Code.

in which the contribution is made and thus is not used to reduce the plan's accumulated funding deficiency for that plan year because the contribution would result in a credit against funding obligations which might arise in the future.

(c) *Defined contribution and welfare plans.* In the context of defined contribution pension plans and welfare plans, it is the view of the Department that an in-kind contribution to a plan that reduces an obligation of a plan sponsor or employer to make a contribution measured in terms of cash amounts would constitute a prohibited transaction under section 406(a)(1)(A) of ERISA (and section 4975(c)(1)(A) of the Code) unless a statutory or administrative exemption under section 408 of ERISA (or sections 4975(c)(2) or (d) of the Code) applies. For example, if a profit sharing plan required the employer to make annual contributions ''in cash or in kind'' equal to a given percentage of the employer's net profits for the year, an in-kind contribution used to reduce this obligation would constitute a prohibited transaction in the absence of an exemption because the amount of the contribution obligation is measured in terms of cash amounts (a percentage of profits) even though the terms of the plan purport to permit in-kind contributions.

Conversely, a transfer of unencumbered property to a welfare benefit plan that does not relieve the sponsor or employer of any present or future obligation to make a contribution that is measured in terms of cash amounts would not constitute a prohibited transaction under section 406(a)(1)(A) of ERISA or section 4975(c)(1)(A) of the Code. The same principles apply to defined contribution plans that are not subject to the minimum funding requirements of section 302 of ERISA or section 412 of the Code. For example, where a profit sharing or stock bonus plan, by its terms, is funded solely at the discretion of the sponsoring employer, and the employer is not otherwise obligated to make a contribution measured in terms of cash amounts, a contribution of unencumbered real property would not be a prohibited sale or exchange between the plan and the employer. If, however, the same employer had made an enforceable promise to make a contribution measured in terms of cash amounts to the plan, a subsequent contribution of unencumbered real property made to offset such an obligation would be a prohibited sale or exchange.

(d) *Fiduciary standards.* Independent of the application of the prohibited transaction provisions, fiduciaries of plans covered by part 4 of title I of ERISA must determine that acceptance of an in-kind contribution is consistent with ERISA's general standards of fiduciary conduct. It is the view of the Department that acceptance of an in-kind contribution is a fiduciary act subject to section 404 of ERISA. In this regard, sections 406(a)(1)(A) and (B) of ERISA require that fiduciaries discharge their duties to a plan solely in the interests of the participants and beneficiaries, for the exclusive purpose of providing benefits and defraying reasonable administrative expenses, and with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims. In addition, section 406(a)(1)(C) requires generally that fiduciaries diversify plan assets so as to minimize the risk of large losses. Accordingly, the fiduciaries of a plan must act ''prudently,'' ''solely in the interest'' of the plan's participants and beneficiaries and with a view to the need to diversify plan assets when deciding whether to accept in-kind contributions. If accepting an in-kind contribution is not ''prudent,'' not ''solely in the interest'' of the participants and beneficiaries of the plan, or would result in an improper lack of diversification of plan assets, the responsible fiduciaries of the plan would be liable for any losses resulting from such a breach of fiduciary responsibility, even if a contribution in kind does not constitute a prohibited transaction under section 406 of ERISA. In this regard, a fiduciary should consider any liabilities appurtenant to the in-kind contribution to which the plan would be exposed as a result of acceptance of the contribution.

[59 FR 66736, Dec. 28, 1994]

§ 2509.95–1 Interpretive bulletin relating to the fiduciary standard under ERISA when selecting an annuity provider.

(a) Scope. This Interpretive Bulletin provides guidance concerning certain fiduciary standards under part 4 of title I of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1104–1114, applicable to the selection of annuity providers for the purpose of pension plan benefit distributions where the plan intends to transfer liability for benefits to the annuity provider.

(b) In General. Generally, when a pension plan purchases an annuity from an insurer as a distribution of benefits, it is intended that the plan's liability for such benefits is transferred to the annuity provider. The Department's regulation defining the term ''participant covered under the plan'' for certain purposes under title I of ERISA recognizes that such a transfer occurs when the annuity is issued by an insurance company licensed to do business in a State. 29 CFR 2510.3–3(d)(2)(ii). Although the regulation does not define the term ''participant'' or ''beneficiary'' for purposes of standing to bring an action under ERISA § 502(a), 29 U.S.C. 1132(a),

it makes clear that the purpose of a benefit distribution annuity is to transfer the plan's liability with respect to the individual's benefits to the annuity provider.

Pursuant to ERISA section 404(a)(1), 29 U.S.C. 1104(a)(1), fiduciaries must discharge their duties with respect to the plan solely in the interest of the participants and beneficiaries. Section 404(a)(1)(A), 29 U.S.C. 1104(a)(1)(A), states that the fiduciary must act for the exclusive purpose of providing benefits to the participants and beneficiaries and defraying reasonable plan administration expenses. In addition, section 404(a)(1)(B), 29 U.S.C. 1104(a)(1)(B), requires a fiduciary to act with the care, skill, prudence and diligence under the prevailing circumstances that a prudent person acting in a like capacity and familiar with such matters would use.

(c) Selection of Annuity Providers. The selection of an annuity provider for purposes of a pension benefit distribution, whether upon separation or retirement of a participant or upon the termination of a plan, is a fiduciary decision governed by the provisions of part 4 of title I of ERISA. In discharging their obligations under section 404(a)(1), 29 U.S.C. 1104(a)(1), to act solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits to the participants and beneficiaries as well as defraying reasonable expenses of administering the plan, fiduciaries choosing an annuity provider for the purpose of making a benefit distribution must take steps calculated to obtain the safest annuity available, unless under the circumstances it would be in the interests of participants and beneficiaries to do otherwise. In addition, the fiduciary obligation of prudence, described at section 404(a)(1)(B), 29 U.S.C. 1104(a)(1)(B), requires, at a minimum, that plan fiduciaries conduct an objective, thorough and analytical search for the purpose of identifying and selecting providers from which to purchase annuities. In conducting such a search, a fiduciary must evaluate a number of factors relating to a potential annuity provider's claims paying ability and creditworthiness. Reliance solely on ratings provided by insurance rating services would not be sufficient to meet this requirement. In this regard, the types of factors a fiduciary should consider would include, among other things:

(1) The quality and diversification of the annuity provider's investment portfolio;

(2) The size of the insurer relative to the proposed contract;

(3) The level of the insurer's capital and surplus;

(4) The lines of business of the annuity provider and other indications of an insurer's exposure to liability;

(5) The structure of the annuity contract and guarantees supporting the annuities, such as the use of separate accounts;

(6) The availability of additional protection through state guaranty associations and the extent of their guarantees. Unless they possess the necessary expertise to evaluate such factors, fiduciaries would need to obtain the advice of a qualified, independent expert. A fiduciary may conclude, after conducting an appropriate search, that more than one annuity provider is able to offer the safest annuity available.

(d) Costs and Other Considerations. The Department recognizes that there are situations where it may be in the interest of the participants and beneficiaries to purchase other than the safest available annuity. Such situations may occur where the safest available annuity is only marginally safer, but disproportionately more expensive than competing annuities, and the participants and beneficiaries are likely to bear a significant portion of that increased cost. For example, where the participants in a terminating pension plan are likely to receive, in the form of increased benefits, a substantial share of the cost savings that would result from choosing a competing annuity, it may be in the interest of the participants to choose the competing annuity. It may also be in the interest of the participants and beneficiaries to choose a competing annuity of the annuity provider offering the safest available annuity is unable to demonstrate the ability to administer the payment of benefits to the participants and beneficiaries. The Department notes, however, that increased cost or other considerations could never justify putting the benefits of annuitized participants and beneficiaries at risk by purchasing an unsafe annuity.

In contrast to the above, a fiduciary's decision to purchase more risky, lower-priced annuities in order to ensure or maximize a reversion of excess assets that will be paid solely to the employer-sponsor in connection with the termination of an over-funded pension plan would violate the fiduciary's duties under ERISA to act solely in the interest of the plan participants and beneficiaries. In such circumstances, the interests of those participants and beneficiaries who will receive annuities lies in receiving the safest annuity available and other participants and beneficiaries have no countervailing interests. The fiduciary in such circumstances must make diligent efforts to assure that the safest available annuity is purchased.

Similarly, a fiduciary may not purchase a riskier annuity solely because there are insufficient assets in a defined benefit plan to purchase a safer annuity. The fiduciary may have to condition the purchase of annuities on additional employer contributions sufficient to purchase the safest available annuity.

(e) Conflicts of Interest. Special care should be taken in reversion situations

where fiduciaries selecting the annuity provider have an interest in the sponsoring employer which might affect their judgment and therefore create the potential for a violation of ERISA §406(b)(1). As a practical matter, many fiduciaries have this conflict of interest and therefore will need to obtain and follow independent expert advice calculated to identify those insurers with the highest claims-paying ability willing to write the business.

[60 FR 12329, Mar. 6, 1995]

§ 2509.96–1 Interpretive bulletin relating to participant investment education.

(a) *Scope.* This interpretive bulletin sets forth the Department of Labor's interpretation of section 3(21)(A)(ii) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and 29 CFR 2510.3–21(c) as applied to the provision of investment-related educational information to participants and beneficiaries in participant-directed individual account pension plans (*i.e.*, pension plans that permit participants and beneficiaries to direct the investment of assets in their individual accounts, including plans that meet the requirements of the Department's regulations at 29 CFR 2550.404c–1).

(b) *General.* Fiduciaries of an employee benefit plan are charged with carrying out their duties prudently and solely in the interest of participants and beneficiaries of the plan, and are subject to personal liability to, among other things, make good any losses to the plan resulting from a breach of their fiduciary duties. ERISA sections 403, 404 and 409, 29 U.S.C. 1103, 1104, and 1109. Section 404(c) of ERISA provides a limited exception to these rules for a pension plan that permits a participant or beneficiary to exercise control over the assets in his or her individual account. The Department of Labor's regulation, at 29 CFR 2550.404c–1, describes the kinds of plans to which section 404(c) applies, the circumstances under which a participant or beneficiary will be considered to have exercised independent control over the assets in his or her account, and the consequences of a participant's or beneficiary's exercise of such control.[1]

With both an increase in the number of participant-directed individual account plans and the number of investment options available to participants and beneficiaries under such plans, there has been an increasing recognition of the importance of providing participants and beneficiaries, whose investment decisions will directly affect their income at retirement, with information designed to assist them in making investment and retirement-related decisions appropriate to their particular situations. Concerns have been raised, however, that the provision of such information may in some situations be viewed as rendering ''investment advice for a fee or other compensation,'' within the meaning of ERISA section 3(21)(A)(ii), thereby giving rise to fiduciary status and potential liability under ERISA for investment decisions of plan participants and beneficiaries.

In response to these concerns, the Department of Labor is clarifying herein the applicability of ERISA section 3(21)(A)(ii) and 29 CFR 2510.3–21(c) to the provision of investment-related educational information to participants and beneficiaries in participant directed individual account plans.[2] In providing this clarification, the Department does not address the ''fee or other compensation, direct or indirect,'' which is a necessary element of fiduciary status under ERISA section 3(21)(A)(ii).[3]

(c) *Investment Advice.* Under ERISA section 3(21)(A)(ii), a person is considered a fiduciary

[1] The section 404(c) regulation conditions relief from fiduciary liability on, among other things, the participant or beneficiary being provided or having the opportunity to obtain sufficient investment information regarding the investment alternatives available under the plan in order to make informed investment decisions. Compliance with this condition, however, does not require that participants and beneficiaries be offered or provided either investment advice or investment education, *e.g.* regarding general investment principles and strategies, to assist them in making investment decisions. 29 CFR 2550.404c–1(c)(4).

[2] Issues relating to the circumstances under which information provided to participants and beneficiaries may affect a participant's or beneficiary's ability to exercise independent control over the assets in his or her account for purposes of relief from fiduciary liability under ERISA section 404(c) are beyond the scope of this interpretive bulletin. Accordingly, no inferences should be drawn regarding such issues. See 29 CFR 2550.404c–1(c)(2). It is the view of the Department, however, that the provision of investment-related information and material to participants and beneficiaries in accordance with paragraph (d) of this interpretive bulletin will not, in and of itself, affect the availability of relief under section 404(c).

[3] The Department has expressed the view that, for purposes of section 3(21)(A)(ii), such fees or other compensation need not come from the plan and should be deemed to include all fees or other compensation incident to the transaction in which the investment advise has been or will be rendered. See A.O. 83–60A (Nov. 21, 1983); *Reich* v. *McManus,* 883 F. Supp. 1144 (N.D. Ill. 1995).

with respect to an employee benefit plan to the extent that person ''renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority to do so * * *.'' The Department issued a regulation, at 29 CFR 2510.3–21(c), describing the circumstances under which a person will be considered to be rendering ''investment advice'' within the meaning of section 3(21)(A)(ii). Because section 3(21)(A)(ii) applies to advice with respect to ''any moneys or other property'' of a plan and 29 CFR 2510.3–21(c) is intended to clarify the application of that section, it is the view of the Department of Labor that the criteria set forth in the regulation apply to determine whether a person renders ''investment advice'' to a pension plan participant or beneficiary who is permitted to direct the investment of assets in his or her individual account.

Applying 29 CFR 2510.3–21(c) in the context of providing investment-related information to participants and beneficiaries of participant-directed individual account pension plans, a person will be considered to be rendering ''investment advice,'' within the meaning of ERISA section 3(21)(A)(ii), to a participant or beneficiary only if: (i) the person renders advice to the participant or beneficiary as to the value of securities or other property, or makes recommendations as to the advisability of investing in, purchasing, or selling securities or other property (2510.3–21(c)(1)(i); and (ii) the person, either directly or indirectly, (A) has discretionary authority or control with respect to purchasing or selling securities or other property for the participant or beneficiary (2510.3–21(c)(1)(ii)(A)), or (B) renders the advice on a regular basis to the participant or beneficiary, pursuant to a mutual agreement, arrangement or understanding (written or otherwise) with the participant or beneficiary that the advice will serve as a primary basis for the participant's or beneficiary's investment decisions with respect to plan assets and that such person will render individualized advice based on the particular needs of the participant or beneficiary (2510.3–21(c)(1)(ii)(B)).[4]

Whether the provision of particular investment-related information or materials to a participant or beneficiary constitutes the rendering of ''investment advice,'' within the meaning of 29 CFR 2510.3–21(c)(1), generally can be determined only by reference to the facts and circumstances of the particular case with respect to the individual plan participant or beneficiary. To facilitate such determinations, however, the Department of Labor has identified, in paragraph (d), below, examples of investment-related information and materials which if provided to plan participants and beneficiaries would not, in the view of the Department, result in the rendering of ''investment advice'' under ERISA section 3(21)(A)(ii) and 29 CFR 2510.3–21(c).

(d) *Investment Education.* For purposes of ERISA section 3(21)(A)(ii) and 29 CFR 2510.3–21(c), the Department of Labor has determined that the furnishing of the following categories of information and materials to a participant or beneficiary in a participant-directed individual account pension plan will not constitute the rendering of ''investment advice,'' irrespective of who provides the information (*e.g.*, plan sponsor, fiduciary or service provider), the frequency with which the information is shared, the form in which the information and materials are provided (*e.g.*, on an individual or group basis, in writing or orally, or via video or computer software), or whether an identified category of information and materials is furnished alone or in combination with other identified categories of information and materials.

(1) *Plan Information.* (i) Information and materials that inform a participant or beneficiary about the benefits of plan participation, the benefits of increasing plan contributions, the impact of preretirement withdrawals on retirement income, the terms of the plan, or the operation of the plan; or

(ii) information such as that described in 29 CFR 2550.404c-1(b)(2)(i) on investment alternatives under the plan (*e.g.*, descriptions of investment objectives and philosophies, risk and return characteristics, historical return information, or related prospectuses).[5]

The information and materials described above relate to the plan and plan participation, without reference to the appropriateness of any individual investment option for a particular participant or beneficiary under the plan. The information, therefore, does not contain either ''advice'' or ''recommendations'' within the meaning of 29 CFR 2510.3–21(c)(1)(i). Accordingly, the furnishing of such information would not constitute the rendering of ''investment advice'' for purposes of section 3(21)(A)(ii) of ERISA.

(2) *General Financial and Investment Information.* Information and materials that inform a participant or beneficiary about: (i) General financial and investment concepts, such as risk and return, diversification, dollar cost averaging, compounded return, and tax deferred investment; (ii) historic differences in rates of return between different

[4] This IB does not address the application of 29 CFR 2510.3–21(c) to communications with fiduciaries of participant-directed individual account pension plan plans.

[5] Descriptions of investment alternatives under the plan may include information relating to the generic asset class (*e,g,*, equities, bonds, or cash) of the investment alternatives. 29 CFR 2550.404c–1 (b)(2)(i)(B)(*1*)(*ii*).

asset classes (*e.g.*, equities, bonds, or cash) based on standard market indices; (iii) effects of inflation; (iv) estimating future retirement income needs; (v) determining investment time horizons; and (vi) assessing risk tolerance.

The information and materials described above are general financial and investment information that have no direct relationship to investment alternatives available to participants and beneficiaries under a plan or to individual participants or beneficiaries. The furnishing of such information, therefore, would not constitute rendering ''advice'' or making ''recommendations'' to a participant or beneficiary within the meaning of 29 CFR 2510.3–21(c)(1)(i). Accordingly, the furnishing of such information would not constitute the rendering of ''investment advice'' for purposes of section 3(21)(A)(ii) of ERISA.

(3) *Asset Allocation Models.* Information and materials (*e.g.*, pie charts, graphs, or case studies) that provide a participant or beneficiary with models, available to all plan participants and beneficiaries, of asset allocation portfolios of hypothetical individuals with different time horizons and risk profiles, where: (i) Such models are based on generally accepted investments theories that take into account the historic returns of different asset classes (*e.g.*, equities, bonds, or cash) over define periods of time; (ii) all material facts and assumptions on which such models are based (*e.g.*, retirement ages, life expectancies, income levels, financial resources, replacement income ratios, inflation rates, and rates of return) accompany the models; (iii) to the extent that an asset allocation model identifies any specific investment alternative available under the plan, the model is accompanied by a statement indicating that other investment alternatives having similar risk and return characteristics may be available under the plan and identifying where information on those investment alternatives may be obtained; and (iv) the asset allocation models are accompanied by a statement indicating that, in applying particular asset allocation models to their individual situations, participants or beneficiaries should consider their other assets, income, and investments (*e.g.*, equity in a home, IRA investments, savings accounts, and interests in other qualified and non-qualified plans) in addition to their interests in the plan.

Because the information and materials described above would enable a participant or beneficiary to assess the relevance of an asset allocation model to his or her individual situation, the furnishing of such information would not constitute a ''recommendation'' within the meaning of 29 CFR 2510.3–21(c)(1)(i) and, accordingly, would not constitute ''investment advice'' for purposes of section 3(21)(A)(ii) of ERISA. This result would not, in the view of the Department, be affected by the fact that a plan offers only one investment alternative in a particular asset class identified in an asset allocation model.

(4) *Interactive Investment Materials.* Questionnaires, worksheets, software, and similar materials which provide a participant or beneficiary the means to estimate future retirement income needs and assess the impact of different asset allocations on retirement income, where: (i) Such materials are based on generally accepted investment theories that take into account the historic returns of different asset classes (*e.g.*, equities, bonds, or cash) over defined periods of time; (ii) there is an objective correlation between the asset allocations generated by the materials and the information and data supplied by the participant or beneficiary; (iii) all material facts and assumptions (*e.g.*, retirement ages, life expectancies, income levels, financial resources, replacement income ratios, inflation rates, and rates of return) which may affect a participant's or beneficiary's assessment of the different asset allocations accompany the materials or are specified by the participant or beneficiary; (iv) to the extent that an asset allocation generated by the materials identifies any specific investment alternative available under the plan, the asset allocation is accompanied by a statement indicating that other investment alternatives having similar risk and return characteristics may be available under the plan and identifying where information on those investment alternatives may be obtained; and (v) the materials either take into account or are accompanied by a statement indicating that, in applying particular asset allocations to their individual situations, participants or beneficiaries should consider their other assets, income, and investments (*e.g.*, equity in a home, IRA investments, savings accounts, and interests in other qualified and non-qualified plans) in addition to their interests in the plan.

The information provided through the use of the above-described materials enables participants and beneficiaries independently to design and assess multiple asset allocation models, but otherwise these materials do not differ from asset allocation models based on hypothetical assumptions. Such information would not constitute a ''recommendation'' within the meaning of 29 CFR 2510.3–21(c)(1)(i) and , accordingly, would not constitute ''investment advice'' for purposes of section 3(21)(A)(ii) of ERISA.

The Department notes that the information and materials described in subparagraphs (1)–(4) above merely represent examples of the type of information and materials which may be furnished to participants and beneficiaries without such information and materials constituting ''investment advice.'' In this regard, the Department recognizes that there may be many other examples of

information, materials, and educational services which, if furnished to participants and beneficiaries, would not constitute ''investment advice.'' Accordingly, no inferences should be drawn from subparagraphs (1)–(4), above, with respect to whether the furnishing of any information, materials or educational services not described therein may constitute ''investment advice.'' Determinations as to whether the provision of any information, materials or educational services not described herein constitutes the rendering of ''investment advice'' must be made by reference to the criteria set forth in 29 CFR 2510. 3–21(c)(1).

(e) *Selection and Monitoring of Educators and Advisors.* As with any designation of a service provider to a plan, the designation of a person(s) to provide investment educational services or investment advice to plan participants and beneficiaries is an exercise of discretionary authority or control with respect to management of the plan; therefore, persons making the designation must act prudently and solely in the interest of the plan participants and beneficiaries, both in making the designation(s) and in continuing such designation(s). See ERISA sections 3(21)(A)(i) and 404(a), 29 U.S.C. 1002 (21)(A)(i) and 1104(a). In addition, the designation of an investment advisor to serve as a fiduciary may give rise to co-fiduciary liability if the person making and continuing such designation in doing so fails to act prudently and solely in the interest of plan participants and beneficiaries; or knowingly participates in, conceals or fails to make reasonable efforts to correct a known breach by the investment advisor. See ERISA section 405(a), 29 U.S.C. 1105(a). The Department notes, however, that, in the context of an ERISA section 404(c) plan, neither the designation of a person to provide education nor the designation of a fiduciary to provide investment advice to participants and beneficiaries would, in itself, give rise to fiduciary liability for loss, or with respect to any breach of part 4 of title I of ERISA, that is the direct and necessary result of a participant's or beneficiary's exercise of independent control. 29 CFR 2550.404c–1(d). The Department also notes that a plan sponsor or fiduciary would have no fiduciary responsibility or liability with respect to the actions of a third party selected by a participant or beneficiary to provide education or investment advice where the plan sponsor or fiduciary neither selects nor endorses the educator or advisor, nor otherwise makes arrangements with the educator or advisor to provide such services.

[61 FR 29588, June 11, 1996]

§ 2509.99–1 Interpretive Bulletin Relating to Payroll Deduction IRAs.

(a) *Scope.* This interpretive bulletin sets forth the Department of Labor's (the Department's) interpretation of section 3(2)(A) of the Employee Retirement Income Security Act of 1974, as amended, (ERISA) and 29 CFR 2510.3–2(d), as applied to payroll deduction programs established by employers[1] for the purpose of enabling employees to make voluntary contributions to individual retirement accounts or individual retirement annuities (IRAs) described in section 408(a) or (b) or section 408A of the Internal Revenue Code (the Code).

(b) *General.* It has been the Department's long-held view that an employer who simply provides employees with the opportunity for making contributions to an IRA through payroll deductions does not thereby establish a ''pension plan'' within the meaning of section 3 (2) (A) of ERISA. In this regard, 29 CFR 2510.3–2 (d) sets forth a safe harbor under which IRAs will not be considered to be pension plans when the conditions of the regulation are satisfied. Thus, an employer may, with few constraints, provide to its employees an opportunity for saving for retirement, under terms and conditions similar to those of certain other optional payroll deduction programs, such as for automatic savings deposits or purchases of United States savings bonds, without thereby creating a pension plan under Title I of ERISA. The guidance provided herein is intended to clarify the application of the IRA safe harbor set forth at 29 CFR 2510.3–2 (d) and, thereby, facilitate the establishment of payroll deduction IRAs.

(c) *Employee Communications.* (1) It is the Department's view that, so long as an employer maintains neutrality with respect to an IRA sponsor in its communications with its employees, the employer will not be considered to ''endorse'' an IRA payroll deduction program for purposes of 29 CFR 2510.3–2(d).[2] An employer may encourage its

[1] The views expressed in this Interpretive Bulletin with respect to payroll deduction programs of employers are also generally applicable to dues checkoff programs of employee organizations.

[2] The Department has specifically stated, in its Advisory Opinions, that an employer may demonstrate its neutrality with respect

Continued

employees to save for retirement by providing general information on the IRA payroll deduction program and other educational materials that explain the advisability of retirement savings, including the advantages of contributing to an IRA, without thereby converting the program under which the employees' wages are withheld for contribution into the IRAs into an ERISA covered plan. However, the employer must make clear that its involvement in the program is limited to collecting the deducted amounts and remitting them promptly to the IRA sponsor and that it does not provide any additional benefit or promise any particular investment return on the employee's savings.

(2)The employer may also do the following without converting a payroll deduction IRA program into an ERISA plan: An employer may answer employees' specific inquiries about the mechanics of the IRA payroll deduction program and may refer other inquiries to the appropriate IRA sponsor. An employer may provide to employees informational materials written by the IRA sponsor describing the sponsor's IRA programs or addressing topics of general interest regarding investments and retirement savings, provided that the material does not itself suggest that the employer is other than neutral with respect to the IRA sponsor and its products; the employer may request that the IRA sponsor prepare such informational materials and it may review such materials for appropriateness and completeness. The fact that the employer's name or logo is displayed in the informational materials in connection with describing the payroll deduction program would not in and of itself, in the Department's view, suggest that the employer has ''endorsed'' the IRA sponsor or its products, provided that the specific context and surrounding facts and circumstances make clear to the employees that the employer's involvement is limited to facilitating employee contributions through payroll deductions.[3]

(d) *Employer Limitations on the number of IRA sponsors offered under the program.* The Department recognizes that the cost of permitting employees to make IRA contributions through payroll deductions may be significantly affected by the number of IRA sponsors to which the employer must remit contributions. It is the view of the Department that an employer may limit the number of IRA sponsors to which employees may make payroll deduction contributions without exceeding the limitations of 29 CFR 2510.3–2(d), provided that any limitations on, or costs or assessments associated with an employee's ability to transfer or roll over IRA contributions to another IRA sponsor is fully disclosed in advance of the employee's decision to participate

to an IRA sponsor in a variety of ways, including (but not limited to) by ensuring that any materials distributed to employees in connection with an IRA payroll deduction program clearly and prominently state, in language reasonably calculated to be understood by the average employee, that the IRA payroll deduction program is completely voluntary; that the employer does not endorse or recommend either the sponsor or the funding media; that other IRA funding media are available to employees outside the payroll deduction program; that an IRA may not be appropriate for all individuals; and that the tax consequences of contributing to an IRA through the payroll deduction program are generally the same as the consequences of contributing to an IRA outside the program. The employer would not be considered neutral, in the Department's view, to the extent that the materials distributed to employees identified the funding medium as having as one of its purposes investing in securities of the employer or its affiliates or the funding medium in fact has any significant investments in such securities. If the IRA program were a result of an agreement between the employer and an employee organization, the Department would view informational materials that identified the funding medium as having as one of its purposes investing in an investment vehicle that is designed to benefit an employee organization by providing more jobs for its members, loans to its members, or similar direct benefits (or the funding medium's actual investments in any such investment vehicles) as indicating the employee organization's involvement in the program in excess of the limitations of 29 CFR 2510.3–2 (d).

[3] For example, if the employer whose logo appeared on the promotional materials provided a statement along the lines of in the first sentence of footnote 5, the employer would not be considered to have endorsed the IRA product.

in the program. The employer may select one IRA sponsor as the designated recipient for payroll deduction contributions, or it may establish criteria by which to select IRA sponsors, e.g., standards relating to the sponsor's provision of investment education, forms, availability to answer employees' questions, etc., and may periodically review its selectees to determine whether to continue to designate them. However, an employer may be considered to be involved in the program beyond the limitations set forth in 29 CFR 2510.3–2(d) if the employer negotiates with an IRA sponsor and thereby obtains special terms and conditions for its employees that are not generally available to similar purchasers of the IRA. The employer's involvement in the IRA program would also be in excess of the limitations of the regulation if the employer exercises any influence over the investments made or permitted by the IRA sponsor.

(e) *Administrative fees.* The employer may pay any fee the IRA sponsor imposes on employers for services the sponsor provides in connection with the establishment and maintenance of the payroll deduction process itself, without exceeding the limitations of 29 CFR 2510.3–2(d). Further, the employer may assume the internal costs (such as for overhead, bookkeeping, etc) of implementing and maintaining the payroll deduction program without reimbursement from either employees or the IRA sponsor without exceeding the limits of the regulation. However, if an employer pays, in connection with operating an IRA payroll deduction program, any administrative, investment management, or other fee that the IRA sponsor would require employees to pay for establishing or maintaining the IRA, the employer would, in the view of the Department, fall outside the safe harbor and, as a result, may be considered to have established a ''pension plan'' for its employees.

(f) *Reasonable Compensation for Services.* 29 CFR 2510.3–2(d) provides that an employer may not receive any consideration in connection with operating an IRA payroll deduction program, but may be paid ''reasonable compensation for services actually rendered in connection with payroll deductions or dues checkoffs.'' Employers have asked whether ''reasonable compensation'' under section 2510.3–2(d) includes payments from an IRA sponsor to an employer for the employer's cost of operating the IRA payroll deduction program. It is the Department's view that the IRA sponsor may make such payments, to the extent that they constitute compensation for the actual costs of the program to the employer. However, ''reasonable compensation'' does not include any profit to the employer. *See* 29 CFR 2510.3–1(j), relating to group or group-type insurance programs. For example, if an IRA sponsor offers to pay an employer an amount equal to a percentage of the assets contributed by employees to IRAs through payroll deduction, such an arrangement might exceed ''reasonable compensation'' for the services actually rendered by the employer in connection with the IRA payroll deduction program. An employer will also be considered to have received consideration that is not ''reasonable compensation'' if the IRA sponsor agrees to make or to permit particular investments of IRA contributions in consideration for the employer's agreement to make a payroll deduction program available to its employees, or if the IRA sponsor agrees to extend credit to or for the benefit of the employer in return for the employer's making payroll deduction available to the employees.

(g) *Additional rules when employer is IRA sponsor or affiliate of IRA sponsor.* Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate[4] of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of § 2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees,

[4] For purposes of this interpretive bulletin, the definition of ''affiliate'' in ERISA section 407(d)(7) applies.

sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type prohibited under § 2510.2(d)(iv) to warrant the program being considered outside the safe harbor of the regulation.[5] Under such circumstances, the employer, in offering payroll deduction contribution opportunities to its employees, would appear to be acting generally as an IRA sponsor, rather than as the employer of the individuals who make the contributions.[6]

[64 FR 33001, June 18, 1999]

[5] While the funding medium offered by an employer that is an IRA sponsor or an affiliate of an IRA sponsor might be considered an employer security when offered to its own employees, the fact that informational materials provided to employees identify the funding medium as having as one of its purposes investing in securities of the employer would not, in the Department's view, involve the employer beyond the limits of 29 CFR 2510.3–2(d). Neither would the fact that the funding medium may actually be so invested. However, the Department would consider that an employer may have exceeded the limitation of 2510.3–2(d) if the informational materials the employer provides to employees suggest that the employer, in providing the IRA payroll deduction program for purposes of investing in employer securities, is acting as an employer in relation to persons who participate in the program, rather than as an IRA sponsor acting in the course of its ordinary business of making IRA products available to the public.

[6] However, if an employer that is an IRA sponsor waives enrollment and management fees for its employees' IRAs, and it normally charges those fees to members of the public who purchase IRAs, the employer would be considered to be so involved in the program as to be outside the safe harbor of the regulation.

SUBCHAPTER B—DEFINITIONS AND COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2510—DEFINITIONS OF TERMS USED IN SUBCHAPTERS C, D, E, F, AND G OF THIS CHAPTER

Sec.
2510.3–1 Employee welfare benefit plan.
2510.3–2 Employee pension benefit plan.
2510.3–3 Employee benefit plan.
2510.3–21 Definition of ''Fiduciary''.
2510.3–37 Multiemployer plan.
2510.3–101 Definition of ''plan assets''—plan investments.
2510.3–102 Definition of ''plan assets''—participant contributions.

AUTHORITY: Secs. 3(2), 111(c), 505, Pub. L. 93–406, 88 Stat. 852, 894, (29 U.S.C. 1002(2), 1031, 1135); Secretary of Labor's Order No. 27–74, 1–86, 1–87, and Labor Management Services Administration Order No. 2–6.

Section 2510.3–101 is also issued under sec. 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978), effective December 31, 1978 (44 FR 1065, January 3, 1978); 3 CFR 1978 Comp. 332, and sec. 11018(d) of Pub. L. 99–272, 100 Stat. 82.

Section 2510.3–102 is also issued under sec. 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978), effective December 31, 1978 (44 FR 1065, January 3, 1978), and 3 CFR 1978 Comp. 332.

§ 2510.3–1 Employee welfare benefit plan.

(a) *General.* (1) The purpose of this section is to clarify the definition of the terms ''employee welfare benefit plan'' and ''welfare plan'' for purposes of title I of the Act and this chapter by identifying certain practices which do not constitute employee welfare benefit plans for those purposes. In addition, the practices listed in this section do not constitute employee pension benefit plans within the meaning of section 3(2) of the Act, and, therefore, do not constitute employee benefit plans within the meaning of section 3(3). Since under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I of the Act, the practices listed in this section are not subject to title I.

(2) The terms ''employee welfare benefit plan'' and ''welfare plan'' are defined in section 3(1) of the Act to include plans providing ''(i) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (ii) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or death, and insurance to provide such pensions).'' Under this definition, only plans which provide benefits described in section 3(1)(A) of the Act or in section 302(c) of the Labor-Management Relations Act, 1947 (hereinafter ''the LMRA'') (other than pensions on retirement or death) constitute welfare plans. For example, a system of payroll deductions by an employer for deposit in savings accounts owned by its employees is not an employee welfare benefit plan within the meaning of section 3(1) of the Act because it does not provide benefits described in section 3(1)(A) of the Act or section 302(c) of the LMRA. (In addition, if each employee has the right to withdraw the balance in his or her account at any time, such a payroll savings plan does not meet the requirements for a pension plan set forth in section 3(2) of the Act and, therefore, is not an employee benefit plan within the meaning of section 3(3) of the Act).

(3) Section 302(c) of the LMRA lists exceptions to the restrictions contained in subsections (a) and (b) of that section on payments and loans made by an employer to individuals and groups representing employees of the employer. Of these exceptions, only those contained in paragraphs (5), (6), (7) and (8) describe benefits provided through employee benefit plans. Moreover, only paragraph (6) describes benefits not described in section 3(1)(A) of the Act. The benefits described in section 302(c)(6) of the LMRA but not in section 3(1)(A) of the Act are ''* * * holiday, severance or similar benefits''. Thus, the effect of section 3(1)(B) of the Act is to include within the definition

of ''welfare plan'' those plans which provide holiday and severance benefits, and benefits which are similar (for example, benefits which are in substance severance benefits, although not so characterized).

(4) Some of the practices listed in this section as excluded from the definition of ''welfare plan'' or mentioned as examples of general categories of excluded practices are inserted in response to questions received by the Department of Labor and, in the Department's judgment, do not represent borderline cases under the definition in section 3(1) of the Act. Therefore, this section should not be read as implicitly indicating the Department's views on the possible scope of section 3(1).

(b) *Payroll practices.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include—

(1) Payment by an employer of compensation on account of work performed by an employee, including compensation at a rate in excess of the normal rate of compensation on account of performance of duties under other than ordinary circumstances, such as—

(i) Overtime pay,

(ii) Shift premiums,

(iii) Holiday premiums,

(iv) Weekend premiums;

(2) Payment of an employee's normal compensation, out of the employer's general assets, on account of periods of time during which the employee is physically or mentally unable to perform his or her duties, or is otherwise absent for medical reasons (such as pregnancy, a physical examination or psychiatric treatment); and

(3) Payment of compensation, out of the employer's general assets, on account of periods of time during which the employee, although physically and mentally able to perform his or her duties and not absent for medical reasons (such as pregnancy, a physical examination or psychiatric treatment) performs no duties; for example—

(i) Payment of compensation while an employee is on vacation or absent on a holiday, including payment of premiums to induce employees to take vacations at a time favorable to the employer for business reasons,

(ii) Payment of compensation to an employee who is absent while on active military duty,

(iii) Payment of compensation while an employee is absent for the purpose of serving as a juror or testifying in official proceedings,

(iv) Payment of compensation on account of periods of time during which an employee performs little or no productive work while engaged in training (whether or not subsidized in whole or in part by Federal, State or local government funds), and

(v) Payment of compensation to an employee who is relieved of duties while on sabbatical leave or while pursuing further education.

(c) *On-premises facilities.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include—

(1) The maintenance on the premises of an employer or of an employee organization of recreation, dining or other facilities (other than day care centers) for use by employees or members; and

(2) The maintenance on the premises of an employer of facilities for the treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours.

(d) *Holiday gifts.* For purposes of title I of the Act and this chapter the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include the distribution of gifts such as turkeys or hams by an employer to employees at Christmas and other holiday seasons.

(e) *Sales to employees.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include the sale by an employer to employees of an employer, whether or not at prevailing market prices, of articles or commodities of the kind which the employer offers for sale in the regular course of business.

(f) *Hiring halls.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include the maintenance by one or more employers, employee organizations, or both, of a hiring hall facility.

(g) *Remembrance funds.* For purposes of title I of the Act and this chapter,

the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include a program under which contributions are made to provide remembrances such as flowers, an obituary notice in a newspaper or a small gift on occasions such as the sickness, hospitalization, death or termination of employment of employees, or members of an employee organization, or members of their families.

(h) *Strike funds.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include a fund maintained by an employee organization to provide payments to its members during strikes and for related purposes.

(i) *Industry advancement programs.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include a program maintained by an employer or group or association of employers, which has no employee participants and does not provide benefits to employees or their dependents, regardless of whether the program serves as a conduit through which funds or other assets are channelled to employee benefit plans covered under title I of the Act.

(j) *Certain group or group-type insurance programs.* For purposes of title I of the Act and this chapter, the terms ''employee welfare benefit plan'' and ''welfare plan'' shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

(k) *Unfunded scholarship programs.* For purposes of title I of the Act and this chapter, the terms ''employe welfare benefit plan'' and ''welfare plan'' shall not include a scholarship program, including a tuition and education expense refund program, under which payments are made solely from the general assets of an employer or employee organization.

[40 FR 34530, Aug. 15, 1975]

§ 2510.3–2 Employee pension benefit plan.

(a) *General.* This section clarifies the limits of the defined terms ''employee pension benefit plan'' and ''pension plan'' for purposes of title I of the Act and this chapter by identifying certain specific plans, funds and programs which do not constitute employee pension benefit plans for those purposes. To the extent that these plans, funds and programs constitute employee welfare benefit plans within the meaning of section 3(1) of the Act and § 2510.3–1 of this part, they will be covered under title I; however, they will not be subject to parts 2 and 3 of title I of the Act.

(b) *Severance pay plans.* (1) For purposes of title I of the Act and this chapter, an arrangement shall not be deemed to constitute an employee pension benefit plan or pension plan solely by reason of the payment of severance benefits on account of the termination of an employee's service, provided that:

(i) Such payments are not contingent, directly or indirectly, upon the employee's retiring;

(ii) The total amount of such payments does not exceed the equivalent of twice the employee's annual compensation during the year immediately preceding the termination of his service; and

(iii) All such payments to any employee are completed,

(A) In the case of an employee whose service is terminated in connection with a limited program of terminations, within the later of 24 months after the termination of the employee's

service, or 24 months after the employee reaches normal retirement age; and

(B) In the case of all other employees, within 24 months after the termination of the employee's service.

(2) For purposes of this paragraph (b),

(i) ''Annual compensation'' means the total of all compensation, including wages, salary, and any other benefit of monetary value, whether paid in the form of cash or otherwise, which was paid as consideration for the employee's service during the year, or which would have been so paid at the employee's usual rate of compensation if the employee had worked a full year.

(ii) ''Limited program of terminations'' means a program of terminations:

(A) Which, when begun, was scheduled to be completed upon a date certain or upon the occurrence of one or more specified events;

(B) Under which the number, percentage or class or classes of employees whose services are to be terminated is specified in advance; and

(C) Which is described in a written document which is available to the Secretary upon request, and which contains information sufficient to demonstrate that the conditions set forth in paragraphs (b)(2)(ii)(A) and (B) of this section have been met.

(c) *Bonus program.* For purposes of title I of the Act and this chapter, the terms ''employee pension benefit plan'' and ''pension plan'' shall not include payments made by an employer to some or all of its employees as bonuses for work performed, unless such payments are systematically deferred to the termination of covered employment or beyond, or so as to provide retirement income to employees.

(d) *Individual Retirement Accounts.* (1) For purposes of title I of the Act and this chapter, the terms ''employee pension benefit plan'' and ''pension plan'' shall not include an individual retirement account described in section 408(a) of the Code, an individual retirement annuity described in section 408(b) of the Internal Revenue Code of 1954 (hereinafter ''the Code'') and an individual retirement bond described in section 409 of the Code, provided that—

(i) No contributions are made by the employer or employee association;

(ii) Participation is completely voluntary for employees or members;

(iii) The sole involvement of the employer or employee organization is without endorsement to permit the sponsor to publicize the program to employees or members, to collect contributions through payroll deductions or dues checkoffs and to remit them to the sponsor; and

(iv) The employer or employee organization receives no consideration in the form of cash or otherwise, other than reasonable compensation for services actually rendered in connection with payroll deductions or dues checkoffs.

(e) *Gratuitous payments to pre-Act retirees.* For purposes of title I of the Act and this chapter the terms ''employee pension benefit plan'' and ''pension plan'' shall not include voluntary, gratuitous payments by an employer to former employees who separated from the service of the employer if:

(1) Payments are made out of the general assets of the employer,

(2) Former employees separated from the service of the employer prior to September 2, 1974,

(3) Payments made to such employees commenced prior to September 2, 1974, and

(4) Each former employee receiving such payments is notified annually that the payments are gratuitous and do not constitute a pension plan.

(f) *Tax sheltered annuities.* For the purpose of title I of the Act and this chapter, a program for the purchase of an annuity contract or the establishment of a custodial account described in section 403(b) of the Internal Revenue Code of 1954 (the Code), pursuant to salary reduction agreements or agreements to forego an increase in salary, which meets the requirements of 26 CFR 1.403(b)–1(b)(3) shall not be ''established or maintained by an employer'' as that phrase is used in the definition of the terms ''employee pension benefit plan'' and ''pension plan'' if

(1) Participation is completely voluntary for employees;

(2) All rights under the annuity contract or custodial account are enforceable solely by the employee, by a beneficiary of such employee, or by any authorized representative of such employee or beneficiary;

(3) The sole involvement of the employer, other than pursuant to paragraph (f)(2) of this section, is limited to any of the following:

(i) Permitting annuity contractors (which term shall include any agent or broker who offers annuity contracts or who makes available custodial accounts within the meaning of section 403(b)(7) of the Code) to publicize their products to employees,

(ii) Requesting information concerning proposed funding media, products or annuity contractors;

(iii) Summarizing or otherwise compiling the information provided with respect to the proposed funding media or products which are made available, or the annuity contractors whose services are provided, in order to facilitate review and analysis by the employees;

(iv) Collecting annuity or custodial account considerations as required by salary reduction agreements or by agreements to forego salary increases, remitting such considerations to annuity contractors and maintaining records of such considerations;

(v) Holding in the employer's name one or more group annuity contracts covering its employees;

(vi) Before February 7, 1978, to have limited the funding media or products available to employees, or the annuity contractors who could approach employees, to those which, in the judgment of the employer, afforded employees appropriate investment opportunities; or

(vii) After February 6, 1978, limiting the funding media or products available to employees, or the annuity contractors who may approach employees, to a number and selection which is designed to afford employees a reasonable choice in light of all relevant circumstances. Relevant circumstances may include, but would not necessarily be limited to, the following types of factors:

(A) The number of employees affected,

(B) The number of contractors who have indicated interest in approaching employees,

(C) The variety of available products,

(D) The terms of the available arrangements,

(E) The administrative burdens and costs to the employer, and

(F) The possible interference with employee performance resulting from direct solicitation by contractors; and

(4) The employer receives no direct or indirect consideration or compensation in cash or otherwise other than reasonable compensation to cover expenses properly and actually incurred by such employer in the performance of the employer's duties pursuant to the salary reduction agreements or agreements to forego salary increases described in this paragraph (f) of this section.

(g) *Supplemental payment plans*—(1) *General rule.* Generally, an arrangement by which a payment is made by an employer to supplement retirement income is a pension plan. Supplemental payments made on or after September 26, 1980, shall be treated as being made under a welfare plan rather than a pension plan for purposes of title I of the Act if all of the following conditions are met:

(i) Payment is made for the purpose of supplementing the pension benefits of a participant or his or her beneficiary out of:

(A) The general assets of the employer, or

(B) A separate trust fund established and maintained solely for that purpose.

(ii) The amount payable under the supplemental payment plan to a participant or his or her beneficiary with respect to a month does not exceed the payee's supplemental payment factor (''SPF,'' as defined in paragraph (g)(3)(i) of this section) for that month, provided however that unpaid monthly amounts may be cumulated and paid in subsequent months to the participant or his or her beneficiary.

(iii) The payment is not made before the last day of the month with respect to which it is computed.

(2) *Safe harbor for arrangements concerning pre-1977 retirees.* (i) Notwithstanding paragraph (g)(1) of this section, effective January 1, 1975 an arrangement by which a payment is made by an employer to supplement the retirement income of a former employee who separated from the service of the employer prior to January 1, 1977 shall be deemed not to have been made under an employee benefit plan if all of the following conditions are met:

(A) The employer is not obligated to make the payment or similar payments for more than twelve months at a time.

(B) The payment is made out of the general assets of the employer.

(C) The former employee is notified in writing at least once each year in which a payment is made that the payments are not part of an employee benefit plan subject to the protections of the Act.

(D) The former employee is notified in writing at least once each year in which a payment is made of the extent of the employer's obligation, if any, to continue the payments.

(ii) A person who receives a payment on account of his or her relationship to a former employee who retired prior to January 1, 1977 is considered to be a former employee for purposes of this paragraph (g)(2).

(3) *Definitions and special rules.* For purposes of this paragraph (g)—

(i) The term ''supplemental payment factor'' (SPF) is, for any particular month, the product of:

(A) The individual's pension benefit amount (as defined in paragraph (g)(3)(ii) of this section), and

(B) The cost of living increase (as defined in paragraph (g)(3)(v) of this section) for that month.

(ii)(A) The term ''pension benefit amount'' (PBA) means, with regard to a retiree, the amount of pension benefits payable, in the form of the annuity chosen by the retiree, for the first full month that he or she is in pay status under a pension plan (as defined in paragraph (g)(3)(iii) of this section) sponsored by his or her employer or under a multiemployer plan in which his or her employer participates. If the retiree has received a lump-sum distribution from the plan, the PBA for the retiree shall be determined as follows:

(*1*) If the plan provides an annuity option at the time of the distribution, the PBA shall be computed as if the distribution had been applied on that date to the purchase from the plan of a level straight annuity for the life of the participant if the participant was unmarried at the time of the distribution or a joint and survivor annuity if the participant was married at the time of distribution.

(*2*) If the plan does not provide an annuity option at the time of the distribution, the PBA shall be computed as if the distribution had been applied on that date to the purchase from an insurance company qualified to do business in a State of a commercially available level straight annuity for the life of the participant if the participant was then single, or a joint and survivor annuity if the participant was then married, based upon the assumption that the participant and beneficiary are standard mortality risks.

(B) If the retiree has received from the plan a series of distributions which do not constitute a lump-sum distribution or an annuity, the PBA for the retiree shall be determined with respect to each distribution according to paragraph (g)(3)(ii)(A) of this section, or in accordance with a reasonably equivalent method.

(C) The term PBA, with regard to the beneficiary of a plan participant, means:

(*1*) The amount of pension benefits, payable in the form of a survivor annuity to the beneficiary, for the first full month that he or she begins to receive the survivor annuity, reduced by:

(*2*) Any increases which have been incorporated as part of the survivor annuity under the plan since the participant entered pay status or, if the participant died before the commencement of pension benefits, since the participant's date of death.

(D) Where a plan participant has commenced to receive his or her pension benefits in the form of a straight-life annuity, or another form of an annuity that does not continue after the participant's death in the form of a survivor annuity, no beneficiary of the participant will have a PBA.

(iii) The term ''pension plan'' means, for purposes of this paragraph (g), a pension plan as defined in section 3(2) of the Act, but not including a plan described in section 4(b), 201(2), or 301(a)(3) of the Act. The term also does not include an arrangement meeting all the conditions of paragraph (g)(1) or (g)(2) of this section or of an arrangement described in § 2510.3–2(e). In the case of a controlled group of corporations within the meaning of section 407(d)(5) of the Act, all pension plans sponsored by members of the group shall be considered to be one pension plan.

(iv) The term ''employer'' means, for purposes of paragraph (g) of this section, the former employer making the supplemental payment. In the case of a contolled group of corporations within the meaning of section 407(d)(7) of the Act, all members of the controlled group shall be considered to be one employer for purposes of this paragraph (g).

(v) The term ''cost of living increase'' (CLI) means, as to any month, a percentage equal to the following fraction:

$$\frac{a-b}{b}$$

where a= the CPIU for the month for which a payment is being computed, and b= the CPIU for the first full month the retiree was in pay status. Where the CLI is calculated for the beneficiary of a plan participant, ''b'' continues to be equal to the CPIU for the first full month the retiree was in pay status. If, however, the participant dies before the commencement of pension benefits, ''b'' is equal to the CPIU for the first full month the survivor is in pay status.

(vi) The term ''CPIU'' means the U.S. City Average All Items Consumer Price Index for all Urban Consumers, published by the U.S. Department of Labor, Bureau of Labor Statistics. Data concerning the CPIU for a particular period can be obtained from the U.S. Department of Labor, Bureau of Labor Statistics, Division of Consumer Prices and Price Indexes, Washington, DC 20212.

(vii) Where an employer does not pay to a retiree the full amount of the supplemental payments which would be permitted under paragraph (g)(1) of this section, any unpaid amounts may be cumulated and paid in subsequent months to either the retiree or the beneficiary of the retiree. The beneficiary need not be the recipient of a survivor annuity in order to be paid these cumulated supplemental payments.

(5) *Examples*. The following examples illustrate how this paragraph (g) works. As referred to in these examples, the CPIU's for July through November of 1980 are as follows:

July 1980: 247.8
August 1980: 249.4
September 1980: 251.7
October 1980: 253.9
November 1980: 256.2

Example (1)(a). E is an employer. R received monthly benefits of $600 under a straight-life annuity under E's defined benefit pension plan after R retired from E and entered pay status on July 1, 1980. The amount that E may pay to R as supplemental payments under a welfare rather than pension plan with respect to the months of July through September of 1980 is computed as follows:

SPF for July 1980:

$$\text{SPF} = \frac{a-b}{b} \times \text{PBA} = \frac{247.8-247.8}{247.8} \times \$600 = \$0.00$$

SPF for August 1980:

$$\text{SPF} = \frac{249.4-247.8}{247.8} \times \$600 = \$3.87$$

SPF for September 1980:

$$\text{SPF} = \frac{251.7-247.8}{247.8} \times \$600 = \$9.44$$

$$\text{Total} = \$0.00 + 3.87 + 9.44 = \$13.31$$

No supplemental payment may be made to R as a welfare plan payment with respect to July 1980, the month of retirement. The $3.87

that may be paid with respect to August 1980 may be paid at any time after August 31, 1980. The $9.44 that may be paid with respect to September 1980 may be paid at any time after September 30, 1980.

Example (1)(b). S is the beneficiary of R. Because R received pension benefits under a straight-life annuity, S will receive no survivor annuity from E after R's death. S thus will have no PBA after R's death and will not be eligible to receive any supplemental payments from E based on S's PBA. To the extent, however, that R did not receive supplemental payments from E to the maximum limit allowable under paragraph (g)(1), any amounts not paid to R may be cumulated and paid to S after R's death.

Example (2)(a). E is an employer. Q received monthly benefits of $500 in the form of a joint and survivor annuity under E's defined benefit pension plan since retirement from E on July 1, 1980. The amount that E may pay to Q as welfare rather than pension plan payments with respect to the months of July through September of 1980 is computed as follows:

SPF for July 1980:

$$\text{SPF} = \frac{247.8 - 247.8}{247.8} \times \$500 = \$0.00$$

SPF for August 1980:

$$\text{SPF} = \frac{249.4 - 247.8}{247.8} \times \$500 = \$3.23$$

SPF for September 1980:

$$\text{SPF} = \frac{251.7 - 247.8}{247.8} \times \$500 = \$7.87$$

$$\text{Total} = \$0.00 + 3.23 + 7.87 = \$11.10$$

No supplemental payment may be made as a welfare plan payment with respect to July 1980, the month of retirement. The $3.23 that may be paid with respect to August 1980 may be paid at any time after August 31, 1980. The $7.87 that may be paid with respect to September 1980 may be paid at any time after September 30, 1980.

Example (2)(b). Q dies on October 15, 1980 without having received any supplemental payments from E. T is the beneficiary of Q. E pays T a survivor's annuity of $300 beginning in November of 1980. The amount payable to T as a survivor annuity under the plan has not been increased since Q began to receive pension benefits. Thus, T's PBA is $300. The amount that E may pay to T as welfare rather than pension plan payments with respect to the months of July through November 1980 is computed as follows:

SPF for July 1980=$0.00
SPF for August 1980=$3.23
SPF for September 1980=$7.87
SPF for October 1980:

$$\text{SPF} = \frac{a - b}{b} \times \text{PBA} = \frac{253.9 - 247.8}{247.8} \times \$500 = \$12.31$$

(Note that T's ''b'' is equal to Q's ''b''.)
SPF for November 1980:

$$\text{SPF} = \frac{256.2 - 247.8}{247.8} \times \$300 = \$10.17$$

Total that may be paid to T

The maximum E may pay T with respect to the months of July through November 1980 as welfare rather than pension plan payments is the sum of those months' SPFs, which is $33.58.

Example (3). Assume the same facts as in Example (1)(a), except that R elected to receive a lump-sum distribution rather than a straight-life annuity. If R is unmarried on July 1, 1980, R's PBA is $600 for the remainder of R's life. If R is married to S on July 1, 1980, the PBAs of R and S are based on the annuity that would have been paid under an election to receive a joint and survivor annuity. See paragraph (g)(3)(ii)(A)(*1*) of this section.

[40 FR 34530, Aug. 15, 1975, as amended at 44 FR 11763, Mar. 2, 1979; 44 FR 23527, Apr. 20, 1979; 47 FR 50240, Nov. 5, 1982; 47 FR 56847, Dec. 21, 1982]

§ 2510.3–3 Employee benefit plan.

(a) *General.* This section clarifies the definition in section 3(3) of the term ''employee benefit plan'' for purposes of title I of the Act and this chapter. It states a general principle which can be applied to a large class of plans to determine whether they constitute employee benefit plans within the meaning of section 3(3) of the Act. Under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I.

(b) *Plans without employees.* For purposes of title I of the Act and this chapter, the term ''employee benefit plan'' shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan, as defined in paragraph (d) of this section. For example, a so-called ''Keogh'' or ''H.R. 10'' plan under which only partners or only a sole proprietor are participants covered under the plan will not be covered under title I. However, a Keogh plan under which one or more common law employees, in addition to the self-employed individuals, are participants covered under the plan, will be covered under title I. Similarly, partnership buyout agreements described in section 736 of the Internal Revenue Code of 1954 will not be subject to title I.

(c) *Employees.* For purposes of this section:

(1) An individual and his or her spouse shall not be deemed to be employees with respect to a trade or business, whether incorporated or unincorporated, which is wholly owned by the individual or by the individual and his or her spouse, and

(2) A partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership.

(d) *Participant covered under the plan.* (1)(i) An individual becomes a participant covered under an employee welfare benefit plan on the earlier of—

(A) The date designated by the plan as the date on which the individual begins participation in the plan;

(B) The date on which the individual becomes eligible under the plan for a benefit subject only to occurrence of the contingency for which the benefit is provided; or

(C) The date on which the individual makes a contribution to the plan, whether voluntary or mandatory.

(ii) An individual becomes a participant covered under an employee pension plan—

(A) In the case of a plan which provides for employee contributions or defines participation to include employees who have not yet retired, on the earlier of—

(*1*) The date on which the individual makes a contribution, whether voluntary or mandatory, or

(*2*) The date designated by the plan as the date on which the individual has satisfied the plan's age and service requirements for participation, and

(B) In the case of a plan which does not provide for employee contributions and does not define participation to include employees who have not yet retired, the date on which the individual completes the first year of employment which may be taken into account in determining—

(*1*) Whether the individual is entitled to benefits under the plan, or

(*2*) The amount of benefits to which the individual is entitled,

whichever results in earlier participation.

(2)(i) An individual is not a participant covered under an employee welfare plan on the earliest date on which the individual—

(A) Is ineligible to receive any benefit under the plan even if the contingency for which such benefit is provided should occur, and

(B) Is not designated by the plan as a participant.

(ii) An individual is not a participant covered under an employee pension plan or a beneficiary receiving benefits under an employee pension plan if—

(A) The entire benefit rights of the individual—

(*1*) Are fully guaranteed by an insurance company, insurance service or insurance organization licensed to do business in a State, and are legally enforceable by the sole choice of the individual against the insurance company, insurance service or insurance organization; and

(*2*) A contract, policy or certificate describing the benefits to which the individual is entitled under the plan has been issued to the individual; or

(B) The individual has received from the plan a lump-sum distribution or a series of distributions of cash or other property which represents the balance of his or her credit under the plan.

(3)(i) In the case of an employee pension benefit plan, an individual who, under the terms of the plan, has incurred a one-year break in service after having become a participant covered

under the plan, and who has acquired no vested right to a benefit before such break in service is not a participant covered under the plan until the individual has completed a year of service after returning to employment covered by the plan.

(ii) For purposes of paragraph (d)(3)(i) of this section, in the case of an employee pension benefit plan which is subject to section 203 of the Act the term ''year of service'' shall have the same meaning as in section 203(b)(2)(A) of the Act and any regulations issued under the Act and the term ''one-year break in service'' shall have the same meaning as in section 203(b)(3)(A) of the Act and any regulations issued under the Act.

[40 FR 34530, Aug. 15, 1975]

§ 2510.3–21 Definition of "Fiduciary."

(a)–(b) [Reserved]

(c) *Investment advice.* (1) A person shall be deemed to be rendering ''investment advice'' to an employee benefit plan, within the meaning of section 3(21)(A)(ii) of the Employee Retirement Income Security Act of 1974 (the Act) and this paragraph, only if:

(i) Such person renders advice to the plan as to the value of securities or other property, or makes recommendation as to the advisability of investing in, purchasing, or selling securities or other property; and

(ii) Such person either directly or indirectly (e.g., through or together with any affiliate)—

(A) Has discretionary authority or control, whether or not pursuant to agreement, arrangement or understanding, with respect to purchasing or selling securities or other property for the plan; or

(B) Renders any advice described in paragraph (c)(1)(i) of this section on a regular basis to the plan pursuant to a mutual agreement, arrangement or understanding, written or otherwise, between such person and the plan or a fiduciary with respect to the plan, that such services will serve as a primary basis for investment decisions with respect to plan assets, and that such person will render individualized investment advice to the plan based on the particular needs of the plan regarding such matters as, among other things, investment policies or strategy, overall portfolio composition, or diversification of plan investments.

(2) A person who is a fiduciary with respect to a plan by reason of rendering investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or having any authority or responsibility to do so, shall not be deemed to be a fiduciary regarding any assets of the plan with respect to which such person does not have any discretionary authority, discretionary control or discretionary responsibility, does not exercise any authority or control, does not render investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, and does not have any authority or responsibility to render such investment advice, provided that nothing in this paragraph shall be deemed to:

(i) Exempt such person from the provisions of section 405(a) of the Act concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

(ii) Exclude such person from the definition of the term ''party in interest'' (as set forth in section 3(14)(B) of the Act) with respect to any assets of the plan.

(d) *Execution of securities transactions.* (1) A person who is a broker or dealer registered under the Securities Exchange Act of 1934, a reporting dealer who makes primary markets in securities of the United States Government or of an agency of the United States Government and reports daily to the Federal Reserve Bank of New York its positions with respect to such securities and borrowings thereon, or a bank supervised by the United States or a State, shall not be deemed to be a fiduciary, within the meaning of section 3(21)(A) of the Act, with respect to an employee benefit plan solely because such person executes transactions for the purchase or sale of securities on behalf of such plan in the ordinary course of its business as a broker, dealer, or bank, pursuant to instructions of a fiduciary with respect to such plan, if:

(i) Neither the fiduciary nor any affiliate of such fiduciary is such broker, dealer, or bank; and

(ii) The instructions specify (A) the security to be purchased or sold, (B) a price range within which such security is to be purchased or sold, or, if such security is issued by an open-end investment company registered under the Investment Company Act of 1940 (15 U.S.C. 80a–1, *et seq.*), a price which is determined in accordance with Rule 22c–1 under the Investment Company Act of 1940 (17 CFR 270.22c–1), (C) a time span during which such security may be purchased or sold (not to exceed five business days), and (D) the minimum or maximum quantity of such security which may be purchased or sold within such price range, or, in the case of a security issued by an open-end investment company registered under the Investment Company Act of 1940, the minimum or maximum quantity of such security which may be purchased or sold, or the value of such security in dollar amount which may be purchased or sold, at the price referred to in paragraph (d)(1)(ii)(B) of this section.

(2) A person who is a broker-dealer, reporting dealer, or bank which is a fiduciary with respect to an employee benefit plan solely by reason of the possession or exercise of discretionary authority or discretionary control in the management of the plan or the management or disposition of plan assets in connection with the execution of a transaction or transactions for the purchase or sale of securities on behalf of such plan which fails to comply with the provisions of paragraph (d)(1) of this section, shall not be deemed to be a fiduciary regarding any assets of the plan with respect to which such broker-dealer, reporting dealer or bank does not have any discretionary authority, discretionary control or discretionary responsibility, does not exercise any authority or control, does not render investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, and does not have any authority or responsibility to render such investment advice, provided that nothing in this paragraph shall be deemed to:

(i) Exempt such broker-dealer, reporting dealer, or bank from the provisions of section 405(a) of the Act concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

(ii) Exclude such broker-dealer, reporting dealer, or bank from the definition, of the term ''party in interest'' (as set forth in section 3(14)(B) of the Act) with respect to any assets of the plan.

(e) *Affiliate and control.* (1) For purposes of paragraphs (c) and (d) of this section, an ''affiliate'' of a person shall include:

(i) Any person directly or indirectly, through one or more intermediaries, controlling, controlled by, or under common control with such person;

(ii) Any officer, director, partner, employee or relative (as defined is section 3(15) of the Act) of such person; and

(iii) Any corporation or partnership of which such person is an officer, director or partner.

(2) For purposes of this paragraph, the term ''control'' means the power to exercise a controlling influence over the management or policies of a person other than an individual.

[40 FR 50843, Oct. 31, 1975]

§ 2510.3–37 Multiemployer plan.

(a) *General.* Section 3(37) of the Act contains in paragraphs (a)(i)–(iv) a number of criteria which an employee benefit plan must meet in order to be a multiemployer plan under the Act. Section 3(37) also provides that the Secretary may prescribe by regulation other requirements in addition to those contained in paragraphs (a)(i)–(iv). The purpose of this regulation is to establish such requirements.

(b) *Plans in existence before the effective date.* (1) A plan in existence before September 2, 1974, will be considered a multiemployer plan if it satisfies the requirements of section 3(37)(A)(i)–(iv) of the Act.

(2) For purposes of this section, a plan is considered to be in existence if:

(i)(A) The plan was reduced to writing and adopted by the participating employers and the employee organization (including, in the case of a corporate employer, formal approval by an

employer's board of directors or shareholders, if required), even though no amounts had been contributed under the plan, and

(B) The plan has not been terminated; or

(ii)(A) There was a legally enforceable agreement to establish such a plan signed by the employers and the employee organization, and

(B) The contributions to be made to the plan were set forth in the agreement.

(iii) If a plan was in existence within the meaning of paragraph (b)(2)(i) or (ii) of this section, any other plan with which such existing plan is merged or consolidated shall also be considered to be in existence.

(c) *Plans not in existence before the effective date.* In addition to the provisions of section 3(37)(A)(i)–(iv) of the Act, a multiemployer plan established on or after September 2, 1974, must meet the requirement that it was established for a substantial business purpose. A substantial business purpose includes the interest of a labor organization in securing an employee benefit plan for its members. The following factors are relevant in determining whether a substantial business purpose existed for the establishment of a plan; any single factor may be sufficient to constitute a substantial business purpose:

(1) The extent to which the plan is maintained by a substantial number of unaffiliated contributing employers and covers a substantial portion of the trade, craft or industry in terms of employees or a substantial number of the employees in the trade, craft or industry in a locality or geographic area;

(2) The extent to which the plan provides benefits more closely related to years of service within the trade, craft or industry rather than with an employer, reflecting the fact that an employee's relationship with an employer maintaining the plan is generally short-term although service in the trade, craft or industry is generally long-term;

(3) The extent to which collective bargaining takes place on matters other than employee benefit plans between the employee organization and the employers maintaining the plan; and

(4) The extent to which the administrative burden and expense of providing benefits through single employer plans would be greater than through a multiemployer plan.

[40 FR 52008, Nov. 7, 1975]

§ 2510.3–101 Definition of "plan assets"—plan investments.

(a) *In general.* (1) This section describes what constitute assets of a plan with respect to a plan's investment in another entity for purposes of subtitle A, and parts 1 and 4 of subtitle B, of title I of the Act and section 4975 of the Internal Revenue Code. Paragraph (a)(2) of this section contains a general rule relating to plan investments. Paragraphs (b) through (f) of this section define certain terms that are used in the application of the general rule. Paragraph (g) of this section describes how the rules in this section are to be applied when a plan owns property jointly with others or where it acquires an equity interest whose value relates solely to identified assets of an issuer. Paragraph (h) of this section contains special rules relating to particular kinds of plan investments. Paragraph (i) describes the assets that a plan acquires when it purchases certain guaranteed mortgage certificates. Paragraph (j) of this section contains examples illustrating the operation of this section. The effective date of this section is set forth in paragraph (k) of this section.

(2) Generally, when a plan invests in another entity, the plan's assets include its investment, but do not, solely by reason of such investment, include any of the underlying assets of the entity. However, in the case of a plan's investment in an equity interest of an entity that is neither a publicly-offered security nor a security issued by an investment company registered under the Investment Company Act of 1940 its assets include both the equity interest and an undivided interest in each of the underlying assets of the entity, unless it is established that—

(i) The entity is an operating company, or

(ii) Equity participation in the entity by benefit plan investors is not significant.

Therefore, any person who exercises authority or control respecting the management or disposition of such underlying assets, and any person who provides investment advice with respect to such assets for a fee (direct or indirect), is a fiduciary of the investing plan.

(b) *Equity interests and publicly-offered securities.* (1) The term *equity interest* means any interest in an entity other than an instrument that is treated as indebtedness under applicable local law and which has no substantial equity features. A profits interest in a partnership, an undivided ownership interest in property and a beneficial interest in a trust are equity interests.

(2) A *publicly-offered security* is a security that is freely transferable, part of a class of securities that is widely held and either—

(i) Part of a class of securities registered under section 12(b) or 12(g) of the Securities Exchange Act of 1934, or

(ii) Sold to the plan as part of an offering of securities to the public pursuant to an effective registration statement under the Securities Act of 1933 and the class of securities of which such security is a part is registered under the Securities Exchange Act of 1934 within 120 days (or such later time as may be allowed by the Securities and Exchange Commission) after the end of the fiscal year of the issuer during which the offering of such securities to the public occurred.

(3) For purposes of paragraph (b)(2) of this section, a class of securities is ''widely-held'' only if it is a class of securities that is owned by 100 or more investors independent of the issuer and of one another. A class of securities will not fail to be widely-held solely because subsequent to the initial offering the number of independent investors falls below 100 as a result of events beyond the control of the issuer.

(4) For purposes of paragraph (b)(2) of this section, whether a security is ''freely transferable'' is a factual question to be determined on the basis of all relevant facts and circumstances. If a security is part of an offering in which the minimum investment is $10,000 or less, however, the following factors ordinarily will not, alone or in combination, affect a finding that such securities are freely transferable:

(i) Any requirement that not less than a minimum number of shares or units of such security be transferred or assigned by any investor, provided that such requirement does not prevent transfer of all of the then remaining shares or units held by an investor;

(ii) Any prohibition against transfer or assignment of such security or rights in respect thereof to an ineligible or unsuitable investor;

(iii) Any restriction on, or prohibition against, any transfer or assignment which would either result in a termination or reclassification of the entity for Federal or state tax purposes or which would violate any state or Federal statute, regulation, court order, judicial decree, or rule of law;

(iv) Any requirement that reasonable transfer or administrative fees be paid in connection with a transfer or assignment;

(v) Any requirement that advance notice of a transfer or assignment be given to the entity and any requirement regarding execution of documentation evidencing such transfer or assignment (including documentation setting forth representations from either or both of the transferor or transferee as to compliance with any restriction or requirement described in this paragraph (b)(4) of this section or requiring compliance with the entity's governing instruments);

(vi) Any restriction on substitution of an assignee as a limited partner of a partnership, including a general partner consent requirement, provided that the economic benefits of ownership of the assignor may be transferred or assigned without regard to such restriction or consent (other than compliance with any other restriction described in this paragraph (b)(4)) of this section;

(vii) Any administrative procedure which establishes an effective date, or an event, such as the completion of the offering, prior to which a transfer or assignment will not be effective; and

(viii) Any limitation or restriction on transfer or assignment which is not created or imposed by the issuer or any

person acting for or on behalf of such issuer.

(c) *Operating company*. (1) An ''operating company'' is an entity that is primarily engaged, directly or through a majority owned subsidiary or subsidiaries, in the production or sale of a product or service other than the investment of capital. The term ''operating company'' includes an entity which is not described in the preceding sentence, but which is a ''venture capital operating company'' described in paragraph (d) or a ''real estate operating company'' described in paragraph (e).

(2) [Reserved]

(d) *Venture capital operating company*. (1) An entity is a ''venture capital operating company'' for the period beginning on an initial valuation date described in paragraph (d)(5)(i) and ending on the last day of the first ''annual valuation period'' described in paragraph (d)(5)(ii) (in the case of an entity that is not a venture capital operating company immediately before the determination) or for the 12 month period following the expiration of an ''annual valuation period'' described in paragraph (d)(5)(ii) (in the case of an entity that is a venture capital operating company immediately before the determination) if—

(i) On such initial valuation date, or at any time within such annual valuation period, at least 50 percent of its assets (other than short-term investments pending long-term commitment or distribution to investors), valued at cost, are invested in venture capital investments described in paragraph (d)(3)(i) or derivative investments described in paragraph (d)(4); and

(ii) During such 12 month period (or during the period beginning on the initial valuation date and ending on the last day of the first annual valuation period), the entity, in the ordinary course of its business, actually exercises management rights of the kind described in paragraph (d)(3)(ii) with respect to one or more of the operating companies in which it invests.

(2)(i) A venture capital operating company described in paragraph (d)(1) shall continue to be treated as a venture capital operating company during the ''distribution period'' described in paragraph (d)(2)(ii). An entity shall not be treated as a venture capital operating company at any time after the end of the distribution period.

(ii) The ''distribution period'' referred to in paragraph (d)(2)(i) begins on a date established by a venture capital operating company that occurs after the first date on which the venture capital operating company has distributed to investors the proceeds of at least 50 percent of the highest amount of its investments (other than short-term investments made pending long-term commitment or distribution to investors) outstanding at any time from the date it commenced business (determined on the basis of the cost of such investments) and ends on the earlier of—

(A) The date on which the company makes a ''new portfolio investment'', or

(B) The expiration of 10 years from the beginning of the distribution period.

(iii) For purposes of paragraph (d)(2)(ii)(A), a ''new portfolio investment'' is an investment other than—

(A) An investment in an entity in which the venture capital operating company had an outstanding venture capital investment at the beginning of the distribution period which has continued to be outstanding at all times during the distribution period, or

(B) A short-term investment pending long-term commitment or distribution to investors.

(3)(i) For purposes of this paragraph (d) a ''venture capital investment'' is an investment in an operating company (other than a venture capital operating company) as to which the investor has or obtains management rights.

(ii) The term ''management rights'' means contractual rights directly between the investor and an operating company to substantially participate in, or substantially influence the conduct of, the management of the operating company.

(4)(i) An investment is a ''derivative investment'' for purposes of this paragraph (d) if it is—

(A) A venture capital investment as to which the investor's management rights have ceased in connection with a

public offering of securities of the operating company to which the investment relates, or

(B) An investment that is acquired by a venture capital operating company in the ordinary course of its business in exchange for an existing venture capital investment in connection with:

(*1*) A public offering of securities of the operating company to which the existing venture capital investment relates, or

(*2*) A merger or reorganization of the operating company to which the existing venture capital investment relates, provided that such merger or reorganization is made for independent business reasons unrelated to extinguishing management rights.

(ii) An investment ceases to be a derivative investment on the later of:

(A) 10 years from the date of the acquisition of the original venture capital investment to which the derivative investment relates, or

(B) 30 months from the date on which the investment becomes a derivative investment.

(5) For purposes of this paragraph (d) and paragraph (e)—

(i) An ''initial valuation date'' is the later of—

(A) Any date designated by the company within the 12 month period ending with the effective date of this section, or

(B) The first date on which an entity makes an investment that is not a short-term investment of funds pending long-term commitment.

(ii) An ''annual valuation period'' is a preestablished annual period, not exceeding 90 days in duration, which begins no later than the anniversary of an entity's initial valuation date. An annual valuation period, once established may not be changed except for good cause unrelated to a determination under this paragraph (d) or paragraph (e).

(e) *Real estate operating company*. An entity is a ''real estate operating company'' for the period beginning on an initial valuation date described in paragraph (d)(5)(i) and ending on the last day of the first ''annual valuation period'' described in paragraph (d)(5)(ii) (in the case of an entity that is not a real estate operating company immediately before the determination) or for the 12 month period following the expiration of an annual valuation period described in paragraph (d)(5)(ii) (in the case of an entity that is a real estate operating company immediately before the determination) if:

(1) On such initial valuation date, or on any date within such annual valuation period, at least 50 percent of its assets, valued at cost (other than short-term investments pending long-term commitment or distribution to investors), are invested in real estate which is managed or developed and with respect to which such entity has the right to substantially participate directly in the management or development activities; and

(2) During such 12 month period (or during the period beginning on the initial valuation date and ending on the last day of the first annual valuation period) such entity in the ordinary course of its business is engaged directly in real estate management or development activities.

(f) *Participation by benefit plan investors*. (1) Equity participation in an entity by benefit plan investors is ''significant'' on any date if, immediately after the most recent acquisition of any equity interest in the entity, 25 percent or more of the value of any class of equity interests in the entity is held by benefit plan investors (as defined in paragraph (f)(2)). For purposes of determinations pursuant to this paragraph (f), the value of any equity interests held by a person (other than a benefit plan investor) who has discretionary authority or control with respect to the assets of the entity or any person who provides investment advice for a fee (direct or indirect) with respect to such assets, or any affiliate of such a person, shall be disregarded.

(2) A ''benefit plan investor'' is any of the following—

(i) Any employee benefit plan (as defined in section 3(3) of the Act), whether or not it is subject to the provisions of title I of the Act,

(ii) Any plan described in section 4975(e)(1) of the Internal Revenue Code,

(iii) Any entity whose underlying assets include plan assets by reason of a plan's investment in the entity.

(3) An ''affiliate'' of a person includes any person, directly or indirectly, through one or more intermediaries, controlling, controlled by, or under common control with the person. For purposes of this paragraph (f)(3), ''control'', with respect to a person other than an individual, means the power to exercise a controlling influence over the management or policies of such person.

(g) *Joint ownership.* For purposes of this section, where a plan jointly owns property with others, or where the value of a plan's equity interest in an entity relates solely to identified property of the entity, such property shall be treated as the sole property of a separate entity.

(h) *Specific rules relating to plan investments.* Notwithstanding any other provision of this section—

(1) Except where the entity is an investment company registered under the Investment Company Act of 1940, when a plan acquires or holds an interest in any of the following entities its assets include its investment and an undivided interest in each of the underlying assets of the entity:

(i) A group trust which is exempt from taxation under section 501(a) of the Internal Revenue Code pursuant to the principles of Rev. Rul. 81–100, 1981–1 C.B. 326,

(ii) A common or collective trust fund of a bank,

(iii) A separate account of an insurance company, other than a separate account that is maintained solely in connection with fixed contractual obligations of the insurance company under which the amounts payable, or credited, to the plan and to any participant or beneficiary of the plan (including an annuitant) are not affected in any manner by the investment performance of the separate account.

(2) When a plan acquires or holds an interest in any entity (other than an insurance company licensed to do business in a State) which is established or maintained for the purpose of offering or providing any benefit described in section 3(1) or section 3(2) of the Act to participants or beneficiaries of the investing plan, its assets will include its investment and an undivided interest in the underlying assets of that entity.

(3) When a plan or a related group of plans owns all of the outstanding equity interests (other than director's qualifying shares) in an entity, its assets include those equity interests and all of the underlying assets of the entity. This paragraph (h)(3) does not apply, however, where all of the outstanding equity interests in an entity are qualifying employer securities described in section 407(d)(5) of the Act, owned by one or more eligible individual account plan(s) (as defined in section 407(d)(3) of the Act) maintained by the same employer, provided that substantially all of the participants in the plan(s) are, or have been, employed by the issuer of such securities or by members of a group of affiliated corporations (as determined under section 407(d)(7) of the Act) of which the issuer is a member.

(4) For purposes of paragraph (h)(3), a ''related group'' of employee benefit plans consists of every group of two or more employee benefit plans—

(i) Each of which receives 10 percent or more of its aggregate contributions from the same employer or from members of the same controlled group of corporations (as determined under section 1563(a) of the Internal Revenue Code, without regard to section 1563(a)(4) thereof); or

(ii) Each of which is either maintained by, or maintained pursuant to a collective bargaining agreement negotiated by, the same employee organization or affiliated employee organizations. For purposes of this paragraph, an ''affiliate'' of an employee organization means any person controlling, controlled by, or under common control with such organization, and includes any organization chartered by the same parent body, or governed by the same constitution and bylaws, or having the relation of parent and subordinate.

(i) *Governmental mortgage pools.* (1) Where a plan acquires a guaranteed governmental mortgage pool certificate, as defined in paragraph (i)(2), the plan's assets include the certificate and all of its rights with respect to such certificate under applicable law, but do not, solely by reason of the plan's holding of such certificate, include any of

the mortgages underlying such certificate.

(2) A ''guaranteed governmental mortgage pool certificate'' is a certificate backed by, or evidencing an interest in, specified mortgages or participation interests therein and with respect to which interest and principal payable pursuant to the certificate is guaranteed by the United States or an agency or instrumentality thereof. The term ''guaranteed governmental mortgage pool certificate'' includes a mortgage pool certificate with respect to which interest and principal payable pursuant to the certificate is guaranteed by:

(i) The Government National Mortgage Association;

(ii) The Federal Home Loan Mortgage Corporation; or

(iii) The Federal National Mortgage Association.

(j) *Examples*. The principles of this section are illustrated by the following examples:

(1) A plan, P, acquires debentures issued by a corporation, T, pursuant to a private offering. T is engaged primarily in investing and reinvesting in precious metals on behalf of its shareholders, all of which are benefit plan investors. By its terms, the debenture is convertible to common stock of T at P's option. At the time of P's acquisition of the debentures, the conversion feature is incidental to T's obligation to pay interest and principal. Although T is not an operating company, P's assets do not include an interest in the underlying assets of T because P has not acquired an *equity* interest in T. However, if P exercises its option to convert the debentures to common stock, it will have acquired an equity interest in T at that time and (assuming that the common stock is not a publicly-offered security and that there has been no change in the composition of the other equity investors in T) P's assets would then include an undivided interest in the underlying assets of T.

(2) A plan, P, acquires a limited partnership interest in a limited partnership, U, which is established and maintained by A, a general partner in U. U has only one class of limited partnership interests. U is engaged in the business of investing and reinvesting in securities. Limited partnership interests in U are offered privately pursuant to an exemption from the registration requirements of the Securities Act of 1933. P acquires 15 percent of the value of all the outstanding limited partnership interests in U, and, at the time of P's investment, a governmental plan owns 15 percent of the value of those interests. U is not an operating company because it is engaged primarily in the investment of capital. In addition, equity participation by benefit plan investors is significant because immediately after P's investment such investors hold more than 25 percent of the limited partnership interests in U. Accordingly, P's assets include an undivided interest in the underlying assets of U, and A is a fiduciary of P with respect to such assets by reason of its discretionary authority and control over U's assets. Although the governmental plan's investment is taken into account for purposes of determining whether equity participation by benefit plan investors is significant, nothing in this section imposes fiduciary obligations on A with respect to that plan.

(3) Assume the same facts as in paragraph (j)(2), except that P acquires only 5 percent of the value of all the outstanding limited partnership interests in U, and that benefit plan investors in the aggregate hold only 10 percent of the value of the limited partnership interests in U. Under these facts, there is no significant equity participation by benefit plan investors in U, and, accordingly, P's assets include its limited partnership interest in U, but do not include any of the underlying assets of U. Thus, A would not be a fiduciary of P by reason of P's investment.

(4) Assume the same facts as in paragraph (j)(3) and that the aggregate value of the outstanding limited partnership interests in U is $10,000 (and that the value of the interests held by benefit plan investors is thus $1000). Also assume that an affiliate of A owns limited partnership interests in U having a value of $6500. The value of the limited partnership interests held by A's affiliate are disregarded for purposes of determining whether there is significant equity participation in U by benefit plan investors. Thus, the percentage of the aggregate value of the limited partnership interests held by benefit plan investors in U for purposes of such a determination is approximately 28.6% ($1000/$3500). Therefore there is significant benefit plan investment in T.

(5) A plan, P, invests in a limited partnership, V, pursuant to a private offering. There is significant equity participation by benefit plan investors in V. V acquires equity positions in the companies in which it invests, and, in connection with these investments, V negotiates terms that give it the right to participate in or influence the management of those companies. Some of these investments are in publicly-offered securities and some are in securities acquired in private offerings. During its most recent valuation period, more than 50 percent of V's assets, valued at cost, consisted of investments with respect to which V obtained management rights of the kind described above. V's managers routinely consult informally with, and advise, the management of only one portfolio

company with respect to which it has management rights, although it devotes substantial resources to its consultations with that company. With respect to the other portfolio companies, V relies on the managers of other entities to consult with and advise the companies' management. V is a venture capital operating company and therefore P has acquired its limited partnership investment, but has not acquired an interest in any of the underlying assets of V. Thus, none of the managers of V would be fiduciaries with respect to P solely by reason of its investment. In this situation, the mere fact that V does not participate in or influence the management of all its portfolio companies does not affect its characterization as a venture capital operating company.

(6) Assume the same facts as in paragraph (j)(5) and the following additional facts: V invests in debt securities as well as equity securities of its portfolio companies. In some cases V makes debt investments in companies in which it also has an equity investment; in other cases V only invests in debt instruments of the portfolio company. V's debt investments are acquired pursuant to private offerings and V negotiates covenants that give it the right to substantially participate in or to substantially influence the conduct of the management of the companies issuing the obligations. These covenants give V more significant rights with respect to the portfolio companies' management than the covenants ordinarily found in debt instruments of established, creditworthy companies that are purchased privately by institutional investors. V routinely consults with and advises the management of its portfolio companies. The mere fact that V's investments in portfolio companies are debt, rather than equity, will not cause V to fail to be a venture capital operating company, provided it actually obtains the right to substantially participate in or influence the conduct of the management of its portfolio companies and provided that in the ordinary course of its business it actually exercises those rights.

(7) A plan, P, invests (pursuant to a private offering) in a limited partnership, W, that is engaged primarily in investing and reinvesting assets in equity positions in real property. The properties acquired by W are subject to long-term leases under which substantially all management and maintenance activities with respect to the property are the responsibility of the lessee. W is not engaged in the management or development of real estate merely because it assumes the risks of ownership of income-producing real property, and W is not a real estate operating company. If there is significant equity participation in W by benefit plan investors, P will be considered to have acquired an undivided interest in each of the underlying assets of W.

(8) Assume the same facts as in paragraph (j)(7) except that W owns several shopping centers in which individual stores are leased for relatively short periods to various merchants (rather than owning properties subject to long-term leases under which substantially all management and maintenance activities are the responsibility of the lessee). W retains independent contractors to manage the shopping center properties. These independent contractors negotiate individual leases, maintain the common areas and conduct maintenance activities with respect to the properties. W has the responsibility to supervise and the authority to terminate the independent contractors. During its most recent valuation period more than 50 percent of W's assets, valued at cost, are invested in such properties. W is a real estate operating company. The fact that W does not have its own employees who engage in day-to-day management and development activities is only one factor in determining whether it is actively managing or developing real estate. Thus, P's assets include its interest in W, but do not include any of the underlying assets of W.

(9) A plan, P, acquires a limited partnership interest in X pursuant to a private offering. There is significant equity participation in X by benefit plan investors. X is engaged in the business of making ''convertible loans'' which are structured as follows: X lends a specified percentage of the cost of acquiring real property to a borrower who provides the remaining capital needed to make the acquisition. This loan is secured by a mortgage on the property. Under the terms of the loan, X is entitled to receive a fixed rate of interest payable out of the initial cash flow from the property and is also entitled to that portion of any additional cash flow which is equal to the percentage of the acquisition cost that is financed by its loan. Simultaneously with the making of the loan, the borrower also gives X an option to purchase an interest in the property for the original principal amount of the loan at the expiration of its initial term. X's percentage interest in the property, if it exercises this option, would be equal to the percentage of the acquisition cost of the property which is financed by its loan. The parties to the transaction contemplate that the option ordinarily will be exercised at the expiration of the loan term if the property has appreciated in value. X and the borrower also agree that, if the option is exercised, they will form a limited partnership to hold the property. X negotiates loan terms which give it rights to substantially influence, or to substantially participate in, the management of the property which is acquired with the proceeds of the loan. These loan terms give X significantly greater rights to participate in the management of the property than it would obtain under a conventional mortgage loan.

In addition, under the terms of the loan, X and the borrower ratably share any capital expenditures relating to the property. During its most recent valuation period, more than 50 percent of the value of X's assets valued at cost consisted of real estate investments of the kind described above. X, in the ordinary course of its business, routinely exercises its management rights and frequently consults with and advises the borrower and the property manager. Under these facts, X is a real estate operating company. Thus, P's assets include its interest in X, but do not include any of the underlying assets of X.

(10) In a private transaction, a plan, P, acquires a 30 percent participation in a debt instrument that is held by a bank. Since the value of the participation certificate relates solely to the debt instrument, that debt instrument is, under paragraph (g), treated as the sole asset of a separate entity. Equity participation in that entity by benefit plan investors is significant since the value of the plan's participation exceeds 25 percent of the value of the instrument. In addition, the hypothetical entity is not an operating company because it is primarily engaged in the investment of capital (*i.e.*, holding the debt instrument). Thus, P's assets include the participation and an undivided interest in the debt instrument, and the bank is a fiduciary of P to the extent it has discretionary authority or control over the debt instrument.

(11) In a private transaction, a plan, P, acquires 30% of the value of a class of equity securities issued by an operating company, Y. These securities provide that dividends shall be paid solely out of earnings attributable to certain tracts of undeveloped land that are held by Y for investment. Under paragraph (g), the property is treated as the sole asset of a separate entity. Thus, even though Y is an operating company, the hypothetical entity whose sole assets are the undeveloped tracts of land is not an operating company. Accordingly, P is considered to have acquired an undivided interest in the tracts of land held by Y. Thus, Y would be a fiduciary of P to the extent it exercises discretionary authority or control over such property.

(12) A medical benefit plan, P, acquires a beneficial interest in a trust, Z, that is not an insurance company licensed to do business in a State. Under this arrangement, Z will provide the benefits to the participants and beneficiaries of P that are promised under the terms of the plan. Under paragraph (h)(2), P's assets include its beneficial interest in Z and an undivided interest in each of its underlying assets. Thus, persons with discretionary authority or control over the assets of Z would be fiduciaries of P.

(k) *Effective date and transitional rules.* (1) In general, this section is effective for purposes of identifying the assets of a plan on or after March 13, 1987. Except as a defense, this section shall not apply to investments in an entity in existence on March 13, 1987, if no plan subject to title I of the Act or plan described in section 4975(e)(1) of the Code (other than a plan described in section 4975(g)(2) or (3)) acquires an interest in the entity from an issuer or underwriter at any time on or after March 13, 1987 except pursuant to a contract binding on the plan in effect on March 13, 1987 with an issuer or underwriter to acquire an interest in the entity.

(2) Notwithstanding paragraph (k)(1), this section shall not, except as a defense, apply to a real estate entity described in section 11018(a) of Pub. L. 99–272.

[51 FR 41280, Nov. 13, 1986, as amended at 51 FR 47226, Dec. 31, 1986]

§ 2510.3–102 Definition of "plan assets"—participant contributions.

(a) *General rule.* For purposes of subtitle A and parts 1 and 4 of subtitle B of title I of ERISA and section 4975 of the Internal Revenue Code only (but without any implication for and may not be relied upon to bar criminal prosecutions under 18 U.S.C. 664), the assets of the plan include amounts (other than union dues) that a participant or beneficiary pays to an employer, or amounts that a participant has withheld from his wages by an employer, for contribution to the plan as of the earliest date on which such contributions can reasonably be segregated from the employer's general assets.

(b) *Maximum time period for pension benefit plans.* (1) Except as provided in paragraph (b)(2), of this section, with respect to an employee pension benefit plan as defined in section 3(2) of ERISA, in no event shall the date determined pursuant to paragraph (a) of this section occur later than the 15th business day of the month following the month in which the participant contribution amounts are received by the employer (in the case of amounts that a participant or beneficiary pays to an employer) or the 15th business day of the month following the month

in which such amounts would otherwise have been payable to the participant in cash (in the case of amounts withheld by an employer from a participant's wages).

(2) With respect to a SIMPLE plan that involves SIMPLE IRAs (*i.e.*, Simple Retirement Accounts, as described in section 408(p) of the Internal Revenue Code), in no event shall the date determined pursuant to paragraph (a) of this section occur later than the 30th calendar day following the month in which the participant contribution amounts would otherwise have been payable to the participant in cash.

(c) *Maximum time period for welfare benefit plans.* With respect to an employee welfare benefit plan as defined in section 3(1) of ERISA, in no event shall the date determined pursuant to paragraph (a) of this section occur later than 90 days from the date on which the participant contribution amounts are received by the employer (in the case of amounts that a participant or beneficiary pays to an employer) or the date on which such amounts would otherwise have been payable to the participant in cash (in the case of amounts withheld by an employer from a participant's wages).

(d) *Extension of maximum time period for pension plans.* (1) With respect to participant contributions received or withheld by the employer in a single month, the maximum time period provided under paragraph (b) of this section shall be extended for an additional 10 business days for an employer who—

(i) Provides a true and accurate written notice, distributed in a manner reasonably designed to reach all the plan participants within 5 business days after the end of such extension period, stating—

(A) That the employer elected to take such extension for that month;

(B) That the affected contributions have been transmitted to the plan; and

(C) With particularity, the reasons why the employer cannot reasonably segregate the participant contributions within the time period described in paragraph (b) of this section;

(ii) Prior to such extension period, obtains a performance bond or irrevocable letter of credit in favor of the plan and in an amount of not less than the total amount of participant contributions received or withheld by the employer in the previous month; and

(iii) Within 5 business days after the end of such extension period, provides a copy of the notice required under paragraph (d)(1)(i) of this section to the Secretary, along with a certification that such notice was provided to the participants and that the bond or letter of credit required under paragraph (d)(1)(ii) of this section was obtained.

(2) The performance bond or irrevocable letter of credit required in paragraph (d)(1)(ii) of this section shall be guaranteed by a bank or similar institution that is supervised by the Federal government or a State government and shall remain in effect for 3 months after the month in which the extension expires.

(3)(i) An employer may not elect an extension under this paragraph (d) more than twice in any plan year unless the employer pays to the plan an amount representing interest on the participant contributions that were subject to all the extensions within such plan year.

(ii) The amount representing interest in paragraph (d)(3)(i) of this section shall be the greater of—

(A) The amount that otherwise would have been earned on the participant contributions from the date on which such contributions were paid to, or withheld by, the employer until such money is transmitted to the plan had such contributions been invested during such period in the investment alternative available under plan which had the highest rate of return; or

(B) Interest at a rate equal to the underpayment rate defined in section 6621(a)(2) of the Internal Revenue Code from the date on which such contributions were paid to, or withheld by, the employer until such money is fully restored to the plan.

(e) *Definition.* For purposes of this section, the term *business day* means any day other than a Saturday, Sunday or any day designated as a holiday by the Federal Government.

(f) *Examples.* The requirements of this section are illustrated by the following examples:

(1) Employer W is a small company with a small number of employees at a

single payroll location. W maintains a plan under section 401(k) of the Code in which all of its employees participate. W's practice is to issue a single check to a trust that is maintained under the plan in the amount of the total withheld employee contributions within two business days of the date on which the employees are paid. In view of the relatively small number of employees and the fact that they are paid from a single location, W could reasonably be expected to transmit participant contributions to the trust within two days after the employee's wages are paid. Therefore, the assets of W's 401(k) plan include the participant contributions attributable to such pay periods as of the date two business days from the date the employee's wages are paid.

(2) Employer X is a large national corporation which sponsors a section 401(k) plan. X has several payroll centers and uses an outside payroll processing service to pay employee wages and process deductions. Each payroll center has a different pay period. Each center maintains separate accounts on its books for purposes of accounting for that center's payroll deductions and provides the outside payroll processor the data necessary to prepare employee paychecks and process deductions. The payroll processing service has adopted a procedure under which it issues the employees' paychecks when due and deducts all payroll taxes and elective employee deductions. It deposits withheld income and employment payroll taxes within the time frame specified by 26 CFR 31.6302–1 and forwards a computer data tape representing the total payroll deductions for each employee, for a month's worth of pay periods, to a centralized location in X, within 4 days after the end of the month, where the data tape is checked for accuracy. A single check representing the aggregate participant contributions for the month is then issued to the plan by the employer. X has determined that this procedure, which takes up to 10 business days to complete, permits segregation of participant contributions at the earliest practicable time and avoids mistakes in the allocation of contribution amounts for each participant. Therefore, the assets of X's 401(k) plan would include the participant contributions no later than 10 business days after the end of the month.

(3) Assume the same facts as in paragraph (f)(2) of this section, except that X takes 30 days after receipt of the data tape to issue a check to the plan representing the aggregate participant contributions for the prior month. X believes that this procedure permits segregation of participant contributions at the earliest practicable time and avoids mistakes in the allocation of contribution amounts for each participant. Under paragraphs (a) and (b) of this section, the assets of the plan include the participant contributions as soon as X could reasonably be expected to segregate the contributions from its general assets, but in no event later than the 15th business day of the month following the month that a participant or beneficiary pays to an employer, or has withheld from his wages by an employer, money for contribution to the plan. The participant contributions become plan assets no later than that date.

(4) Employer Y is a medium-sized company which maintains a self-insured contributory group health plan. Several former employees have elected, pursuant to the provisions of ERISA section 602, 29 U.S.C. 1162, to pay Y for continuation of their coverage under the plan. These checks arrive at various times during the month and are deposited in the employer's general account at bank Z. Under paragraphs (a) and (b) of this section, the assets of the plan include the former employees' payments as soon after the checks have cleared the bank as Y could reasonably be expected to segregate the payments from its general assets, but in no event later than the 90 days after a participant or beneficiary, including a former employee, pays to an employer, or has withheld from his wages by an employer, money for contribution to the plan.

(g) *Effective date.* This section is effective February 3, 1997.

(h) *Applicability date for collectively-bargained plans.* (1) Paragraph (b) of this section applies to collectively bargained plans no sooner than the later of—

(i) February 3, 1997; or

(ii) The first day of the plan year that begins after the expiration of the last to expire of any applicable bargaining agreement in effect on August 7, 1996.

(2) Until paragraph (b) of this section applies to a collectively bargained plan, paragraph (c) of this section shall apply to such plan as if such plan were an employee welfare benefit plan.

(i) *Optional postponement of applicability*. (1) The application of paragraph (b) of this section shall be postponed for up to an additional 90 days beyond the effective date described in paragraph (g) of this section for an employer who, prior to February 3, 1997—

(i) Provides a true and accurate written notice, distributed in a manner designed to reach all the plan participants before the end of February 3, 1997, stating—

(A) That the employer elected to postpone such applicability;

(B) The date that the postponement will expire; and

(C) With particularity the reasons why the employer cannot reasonably segregate the participant contributions within the time period described in paragraph (b) of this section, by February 3, 1997;

(ii) Obtains a performance bond or irrevocable letter of credit in favor of the plan and in an amount of not less than the total amount of participant contributions received or withheld by the employer in the previous 3 months;

(iii) Provides a copy of the notice required under paragraph (i)(1)(i) of this section to the Secretary, along with a certification that such notice was provided to the participants and that the bond or letter of credit required under paragraph (i)(1)(ii) of this section was obtained; and

(iv) For each month during which such postponement is in effect, provides a true and accurate written notice to the plan participants indicating the date on which the participant contributions received or withheld by the employer during such month were transmitted to the plan.

(2) The notice required in paragraph (i)(1)(iv) of this section shall be distributed in a manner reasonably designed to reach all the plan participants within 10 days after transmission of the affected participant contributions.

(3) The bond or letter of credit required under paragraph (i)(1)(ii) shall be guaranteed by a bank or similar institution that is supervised by the Federal government or a State government and shall remain in effect for 3 months after the month in which the postponement expires.

(4) During the period of any postponement of applicability with respect to a plan under this paragraph (i), paragraph (c) of this section shall apply to such plan as if such plan were an employee welfare benefit plan.

[61 FR 41233, Aug. 7, 1996, as amended at 62 FR 62936, Nov. 25, 1997]

SUBCHAPTER C—REPORTING AND DISCLOSURE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2520—RULES AND REGULATIONS FOR REPORTING AND DISCLOSURE

Subpart A—General Reporting and Disclosure Requirements

Sec.
2520.101–1 Duty of reporting and disclosure.
2520.101–2 Annual reporting by multiple employer welfare arrangements and certain other entities offering or providing coverage for medical care to the employees of two or more employers.

Subpart B—Contents of Plan Descriptions and Summary Plan Descriptions

2520.102–1 [Reserved]
2520.102–2 Style and format of summary plan description.
2520.102–3 Contents of summary plan description.
2520.102–4 Option for different summary plan descriptions.

Subpart C—Annual Report Requirements

2520.103–1 Contents of the annual report.
2520.103–2 Contents of the annual report for a group insurance arrangement.
2520.103–3 Exemption from certain annual reporting requirements for assets held in a common or collective trust.
2520.103–4 Exemption from certain annual reporting requirements for assets held in an insurance company pooled separate account.
2520.103–5 Transmittal and certification of information to plan administrator for annual reporting purposes.
2520.103–6 Definition of reportable transaction for Annual Return/Report.
2520.103–8 Limitation on scope of accountant's examination.
2520.103–9 Direct filing for bank or insurance carrier trusts and accounts.
2520.103–10 Annual report financial schedules.
2520.103–11 Assets held for investment purposes.
2520.103–12 Limited exemption and alternative method of compliance for annual reporting of investments in certain entities.

Subpart D—Provisions Applicable to Both Reporting and Disclosure Requirements

2520.104–1 General.
2520.104–2—2520.104–3 [Reserved]
2520.104–4 Alternative method of compliance for certain successor pension plans.
2520.104–5—2520.104–6 [Reserved]
2520.104–20 Limited exemption for certain small welfare plans.
2520.104–21 Limited exemption for certain group insurance arrangements.
2520.104–22 Exemption from reporting and disclosure requirements for apprenticeship and training plans.
2520.104–23 Alternative method of compliance for pension plans for certain selected employees.
2520.104–24 Exemption for welfare plans for certain selected employees.
2520.104–25 Exemption from reporting and disclosure for day care centers.
2520.104–26 Limited exemption for certain unfunded dues financed welfare plans maintained by employee organizations.
2520.104–27 Alternative method of compliance for certain unfunded dues financed pension plans maintained by employee organizations.
2520.104–28 [Reserved]
2520.104–41 Simplified annual reporting requirements for plans with fewer than 100 participants.
2520.104–42 Waiver of certain actuarial information in the annual report.
2520.104–43 Exemption from annual reporting requirement for certain group insurance arrangements.
2520.104–44 Limited exemption and alternative method of compliance for annual reporting by unfunded plans and by certain insured plans.
2520.104–45 [Reserved]
2520.104–46 Waiver of examination and report of an independent qualified public accountant for employee benefit plans with fewer than 100 participants.
2520.104–47 Limited exemption and alternative method of compliance for filing of insurance company financial reports.
2520.104–48 Alternative method of compliance for model simplified employee pensions—IRS Form 5305–SEP.
2520.104–49 Alternative method of compliance for certain simplified employee pensions.
2520.104–50 Short plan years, deferral of accountant's examination and report.

Subpart E—Reporting Requirements

2520.104a–1 Filing with the Secretary of Labor.
2520.104a–2—2520.104a–4 [Reserved]
2520.104a–5 Annual report filing requirements.

2520.104a–6 Annual reporting for plans which are part of a group insurance arrangement.
2520.104a–7 [Reserved]
2520.104a–8 Requirement to furnish documents to the Secretary of Labor on request.

Subpart F—Disclosure Requirements

2520.104b–1 Disclosure.
2520.104b–2 Summary plan description.
2520.104b–3 Summary of material modifications to the plan and changes in the information required to be included in the summary plan description.
2520.104b–4 Alternative methods of compliance for furnishing the summary plan description and summaries of material modifications of a pension plan to a retired participant, a separated participant with vested benefits, and a beneficiary receiving benefits.
2520.104b–10 Summary Annual Report.
2520.104b–30 Charges for documents.

Subpart G—Recordkeeping Requirements

2520.107–1 Use of electronic media for maintenance and retention or records.

AUTHORITY: Secs. 101, 102, 103, 104, 105, 109, 110, 111(b)(2), 111(c), 502(c)(5), 505, 701–703, 711–713, 731–734 Pub. L. 93–406, 88 Stat. 840–852 and 894 (29 U.S.C. 1021–1025, 1029–1031, 1135, 1171–1173, 1181–1183, 1191–1194), as amended by Pub. L. 104–191, 101 Stat. 1936 and Pub. L. 104–204, 101 Stat. 2944; Secretary of Labor's Order No. 27–74, 13–76, 1–87, and Labor Management Services Administration Order 2–6.

Sections 2520.102–3, 2520.104b–1 and 2520.104b–3 are also issued under sec. 101(a), (c) and (g)(4) of Pub. L. 104–191, 110 Stat. 1936, 1939, 1951 and 1955 and sec. 603 of Pub. L. 104–204, 110 Stat. 2935 (29 U.S.C. 1185 and 1191c).

EFFECTIVE DATE NOTE: At 67 FR 17274, Apr. 9, 2002, the authority for part 2520 was revised, effective Oct. 9, 2002. For the convenience of the user, the revised text is set forth as follows:

AUTHORITY: Secs. 101, 102, 103, 104, 105, 107, 109, 110, 111(b)(2), 111(c), 209, and 505, Pub. L. 93–406, 88 Stat. 840–52, 865, 893 and 894 (29 U.S.C. 1021–1025, 1027, 1029–31, 1059, 1134 and 1135); Secretary of Labor's Order No. 27–74, 13–76, 1–87, and Labor Management Services Administration Order 2–6. Sections 2520.102–3, 2520.104b–1 and 2520.104b–3 also are issued under sec. 101(a), (c) and (g)(4) of Pub. L. 104–191, 110 Stat. 1936, 1939, 1951 and 1955 and, sec. 603 of Pub. L. 104–204, 110 Stat. 2935 (29 U.S.C. 1185 and 1191c). Sections 2520.104b–1 and 2520.107 are also issued under the authority of sec. 1510 of Pub. L. 105–37, 111 Stat. 1114.

Subpart A—General Reporting and Disclosure Requirements

§ 2520.101–1 Duty of reporting and disclosure.

The procedures for implementing the plan administrator's duty of reporting to the Secretary of Labor and disclosing information to participants and beneficiaries are located in subparts D, E and F of this part.

(Approved by the Office of Management and Budget under control number 1210–0016)

[41 FR 16962, Apr. 23, 1976, as amended at 46 FR 62845, Dec. 29, 1981]

§ 2520.101–2 Annual reporting by multiple employer welfare arrangements and certain other entities offering or providing coverage for medical care to the employees of two or more employers.

(a) *Basis and scope.* Section 101(g){h}[1] of the Act permits the Secretary of Labor to require, by regulation, multiple employer welfare arrangements (MEWAs) providing benefits that consist of medical care (within the meaning of section 733(a)(2) of the Act), and that are not group health plans, to report, not more frequently than annually, in such form and manner as the Secretary may require, for the purpose of determining the extent to which the requirements of part 7 of the Act are being carried out in connection with such benefits. Section 734 of the Act provides that the Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of part 7 of the Act. This section sets out requirements for annual reporting by MEWAs that provide benefits that consist of medical care and by certain entities that claim not to be a MEWA solely due to the exception in section 3(40)(A)(i) of the Act (Entities Claiming Exception or ECEs). These requirements apply regardless of

[1] Section 1421(d)(1) of the Small Business Job Protection Act of 1996 (Pub. L. 104–188) created a new section 101(g) of ERISA relating to Simple Retirement Accounts. Subsequently, section 101(e)(1) of HIPAA also created a new section 101(g) of ERISA relating to MEWA reporting. Accordingly, when referring to section 101(g) of ERISA relating to MEWA reporting, this document cites section 101(g){h} of ERISA.

whether the MEWA or ECE is a group health plan.

(b) *Definitions*. As used in this section, the following definitions apply:

Administrator means—

(1) The person specifically so designated by the terms of the instrument under which the MEWA or ECE is operated;

(2) If the MEWA or ECE is a group health plan and the administrator is not so designated, the plan sponsor (as defined in section 3(16)(B) of the Act); or

(3) In the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot be identified, the person or persons actually responsible (whether or not so designated under the terms of the instrument under which the MEWA or ECE is operated) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent, custodian, or trustee designated by such person or persons.

Entity Claiming Exception (ECE) means an entity that claims it is not a MEWA due to the exception in section 3(40)(A)(i) of the Act. (In general, this exception is for entities that are established and maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements).

Group health plan means a *group health plan* within the meaning of section 733(a) of the Act and § 2590.701–2.

Health insurance issuer means a *health insurance issuer* within the meaning of section 733(b)(2) of the Act and § 2590.701–2.

Medical care means *medical care* within the meaning of section 733(a)(2) of the Act and § 2590.701–2.

Multiple employer welfare arrangement (MEWA) means a multiple employer welfare arrangement within the meaning of section 3(40) of the Act.

Origination means the occurrence of any of the following three events (and a MEWA or ECE is considered to have been *originated* when any of the following three events occurs)—

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);

(2) The MEWA or ECE begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals) after a merger with another MEWA or ECE (unless all of the MEWAs or ECEs that participate in the merger previously were last originated at least three years prior to the merger); or

(3) The number of employees receiving coverage for medical care under the MEWA or ECE is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless the increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

(c) *Persons required to report*—(1) *General rule*. Except as provided in paragraph (c)(2) of this section, the following persons are required to report under this section—

(i) The administrator of a MEWA that offers or provides benefits consisting of medical care, regardless of whether the entity is a group health plan; and

(ii) The administrator of an ECE that offers or provides benefits consisting of medical care during the first three years after the ECE is originated.

(2) *Exception*. Nothing in this paragraph (c) shall be construed to require reporting under this section by the administrator of a MEWA or ECE if the MEWA or ECE is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees.

(3) *Construction*. For purposes of this section, the following rules of construction apply—

(i) Whether or not an entity is a MEWA or ECE is determined by the administrator acting in good faith. Therefore, if an administrator makes a good faith determination at the time when a filing under this section would otherwise be required that the entity is

maintained pursuant to one or more collective bargaining agreements, the entity is an ECE, and the administrator of the ECE is not required to file if its most recent origination was more than three years. Even if the entity is later determined to be a MEWA, filings are not required prior to the determination that the entity is a MEWA if at the time the filings were otherwise due, the administrator made a good faith determination that the entity was an ECE. However, filings are required for years after the determination that the entity is a MEWA.

(ii) In contrast, while an administrator's good faith determination that an entity is an ECE may eliminate the requirement that the administrator of the entity file under this section for more than three years after the entity's origination date, the administrator's determination, nonetheless, does not affect the applicability of State law to the entity. Accordingly, incorrectly claiming the exception may eliminate the need to file under this section, if the claiming of the exception is done in good faith. However, the claiming of the exception for ECEs under this filing requirement does not prevent the application of State law to an entity that is later determined to be a MEWA. This is because the filing, or the failure to file, under this section does not in any way affect the application of State law to a MEWA.

(d) *Information to be reported.* (1) The annual report required by this section shall consist of a completed copy of the Form M–1 ''Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)'' (Form M–1) and any additional statements required in the instructions to the Form M–1. This report is available by calling 1–800–998–7542 and on the Internet at http://www.dol.gov/dol/pwba.

(2) The Secretary may reject any filing under this section if the Secretary determines that the filing is incomplete, in accordance with § 2560.502c–5.

(3) If the Secretary rejects a filing under paragraph (d)(2) of this section, and if a revised filing satisfactory to the Secretary is not submitted within 45 days after the notice of rejection, the Secretary may bring a civil action for such relief as may be appropriate (including penalties under section 502(c)(5) of the Act and § 2560.502c–5).

(e) *Timing*—(1) *Period to be Reported.* A completed copy of the Form M–1 is required to be filed for each calendar year during all or part of which the MEWA or ECE offers or provides coverage for medical care to the employees of two or more employers (including one or more self-employed individuals).

(2) *Filing deadline*—(i) *General March 1 filing due date.* Subject to the transition rule described in paragraph (e)(2)(ii) of this section, a completed copy of the Form M–1 is required to be filed on or before each March 1 that follows a period to be reported (as described in paragraph (e)(1) of this section). However, if March 1 is a Saturday, Sunday, or federal holiday, the form must be filed no later than the next business day.

(ii) *Transition rule for Year 2000 filings.* For the year 1999 period to be reported, a completed copy of the Form M–1 is required to be filed no later than May 1, 2000.

(iii) *Special rule requiring a 90–Day Origination Report when a MEWA or ECE is originated*—(A) *In general.* Subject to paragraph (e)(2)(ii)(B) of this section, when a MEWA or ECE is originated, the administrator of the MEWA or ECE is also required to file a completed copy of the Form M–1 within 90 days of the origination date (unless 90 days after the origination date is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the next business day).

(B) *Exceptions.* (*1*) Paragraph (d)(2)(ii)(A) of this section does not apply if the origination occurred between October 1 and December 31.

(*2*) Paragraph (d)(2)(ii)(A) of this section does not apply before May 1, 2000. Therefore, for an entity that is originated, for example, on January 1, 2000, no 90–day origination report is required. Nonetheless, for an entity originated, for example, on April 1, 2000, a 90–day origination report is required to be completed and filed no later than June 30, 2000.

(iv) *Extensions.* An extension may be granted for filing a report if the administrator complies with the extension

procedure prescribed in the Instructions to the Form M–1.

(f) *Filing address.* A completed copy of the Form M–1 is filed with the Secretary by sending it to the address prescribed in the Instructions to the Form M–1.

(g) *Civil penalties and procedures.* For information on civil penalties under section 502(c)(5) of the Act for persons who fail to file the information required under this section (including a transition rule applicable to filings due in the year 2000), see § 2560.502c–5. For information relating to administrative hearings and appeals in connection with the assessment of civil penalties under section 502(c)(5) of the Act, see § 2570.90 *et seq.*

(h) *Examples.* The rules of this section are illustrated by the following examples:

Example 1. (i) MEWA *A* began offering coverage for medical care to the employees of two or more employers July 1, 1989 (and continuous to offer such coverage). MEWA *A* does not claim the exception under section 3(40)(A)(i) of ERISA.

(ii) In this *Example 1,* the administrator of MEWA *A* must file a completed copy of the Form M–1 by May 1, 2000. Furthermore, the administrator of MEWA *A* must file the Form M–1 annually by every March 1 thereafter.

Example 2. (i) ECE *B* began offering coverage for medical care to the employees of two or more employers on January 1, 1992. ECE *B* has not been involved in any mergers and in 1999 the number of employees to which ECE *B* provides coverage for medical care is not at least 50 percent greater than the number of such employees on December 31, 1998.

(ii) In this *Example 2,* ECE *B* was originated was on January 1, 1992 has not been originated since then. Therefore, the administrator of ECE *B* is not required to file a Form M–1 on May 1, 2000 because the last time the ECE *B* was originated was January 1, 1992 which more than 3 years prior to May 1, 2000.

Example 3. (i) ECE *C* began offering coverage for medical care to the employees of two or more employers on July 1, 1998.

(ii) In this *Example 3,* the administrator of ECE *C* must file a completed copy of the Form M–1 by May 1, 2000 because the last date *A* was originated was July 1, 1998, which is less than 3 years prior to the May 1, 2000 due date. Furthermore, the administrator of ECE *C* must file a year 2000 annual report by March 1, 2001 (because July 1, 1998 is less than three years prior to March 1, 2001). However, if ECE *C* is not involved in any mergers that would result in a new origination date and if ECE *C* does not experience a growth of 50 percent or more in the number of employees to which ECE *C* provides coverage from the last day of the previous calendar year to any day in the current calendar year, then no Form M–1 report is required to be filed after March 1, 2001.

Example 4. (i) MEWA *D* begins offering coverage to the employees of two or more employers on January 1, 2000. MEWA *D* is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

(ii) In this *Example 4,* the administrator of MEWA *D* is not required to file Form M–1 on May 1, 2000 because it is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

Example 5. (i) MEWA *E* is originated on September 1, 2000.

(ii) In this *Example 5,* because MEWA *E* was originated on September 1, 2000, the administrator of MEWA *E* must file a completed copy of the Form M–1 on or before November 30, 2000 (which is 90 days after the origination date). In addition, the administrator of MEWA *E* must file a completed copy of the Form M–1 annually by every March 1 thereafter.

(i) *Compliance dates*—(1) Subject to paragraph (i)(2) of this section, reports filed pursuant to this reporting requirement are first due by May 1, 2000. (Therefore, on May 1, 2000, filings are due with respect to MEWAs or ECEs that provided coverage in calendar year 1999.)

(2) 90-Day Origination Reports (described in paragraph (e)(2)(ii) of this section) are first due by May 1, 2000. Therefore, for an entity that is originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity originated, for example, on April 1, 2000, a 90-day origination report is required to be completed and filed no later than June 30, 2000.

1999 Form M-1 MEWA/ECE Form This Form is Open to Public Inspection	Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs) This report is required to be filed under section 101(g)(h) of the Employee Retirement Income Security Act of 1974 and 29 CFR 2520.101-2. ➤ See separate instructions before completing this form.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

PART I ANNUAL REPORT IDENTIFICATION INFORMATION

Complete either Item **A** or Item **B**, as applicable.

A If this is an annual report, specify whether it is for:
(*1*) ☐ The 1999 calendar year; or
(*2*) ☐ The fiscal year beginning _____, _____ and ending _____, _____.

B If this is a special filing, specify whether it is:
(*1*) ☐ A 90-day origination report;
(*2*) ☐ An amended report; or
(*3*) ☐ A request for an extension.

PART II MEWA OR ECE IDENTIFICATION INFORMATION

1a Name and address of the MEWA or ECE	**1b** Telephone number of the MEWA or ECE
	1c Employer Identification Number (EIN)
	1d Plan Number (PN)
2a Name and address of the administrator of the MEWA or ECE	**2b** Telephone number of the administrator
	2c Employer Identification Number (EIN)
3a Name and address of the entity sponsoring the MEWA or ECE	**3b** Telephone number of the sponsor
	3c Employer Identification Number (EIN)

PART III REGISTRATION INFORMATION

4 Specify the most recent date the MEWA or ECE was originated . . . . . ➤ _____

5 Complete the following chart. (See Instructions for **Item 5**)

5a	5b	5c	5d	5e	5f	5g
Enter all States where the entity offers or provides coverage.	Is the entity a licensed health insurance issuer in this State?	If you answer "yes" to **5b**, list any NAIC number.	If you answer "no," to **5b**, is the entity fully-insured?	If you answer "yes" to **5d**, enter the name of the insurer and its NAIC number.	Does the entity purchase stop-loss coverage?	If you answer "yes" to **5f**, enter the name of the stop-loss insurer and its NAIC number.
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	
	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ No	

You may attach additional pages if necessary.

For Paperwork Reduction Act Notice, see page 1 of the instructions.

6 Of the States identified in **Item 5a**, list those States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

7 Total number of participants covered under the MEWA or ECE . . . . . ➤ _____

PART IV INFORMATION FOR COMPLIANCE WITH PART 7 OF ERISA

8a Has the MEWA or ECE been involved in any litigation or enforcement proceeding in which noncompliance with any provision of Part 7 of Subtitle B of Title I of ERISA was alleged? Answer for the year to which this filing applies and any time since then up to the date of completing this form. Answer "Yes" for any State, federal, administrative litigation or enforcement proceeding, whether the allegation concerns a provision under Part 7 of ERISA, a corresponding provision under the Internal Revenue Code or Public Health Service Act, a breach of any duty under Title I of ERISA if the underlying violation relates to a requirement under Part 7 of ERISA, or a breach of a contractual obligation if the contract provision relates to a requirement under Part 7 of ERISA. (The instructions to this form contain additional information that may be helpful in answering this question.) . . . . . ➤ ☐ Yes ☐ No

8b If you answered "Yes" to **Item 8a**, identify each litigation or enforcement proceeding. With respect to each, include: (1) the case number (if any), (2) the date, (3) the nature of the proceedings, (4) the court, (5) all parties (for example, plaintiffs and defendants or petitioners and respondents), and (6) the disposition. You may answer this question by attaching a copy of the complaint with the disposition of the case noted in the upper right corner. If you need additional space, you may attach additional pages.

9 Complete the following. (Note: The instructions to this form contain four detailed worksheets which may be helpful in completing this item. Please read the instructions carefully before answering the following questions.)

9a	Is the MEWA or ECE in compliance with the portability provisions of the Health Insurance Portability and Accountability Act of 1996 and the Department's regulations issued thereunder? (See Worksheet A) . . . . . ➤	☐ Yes ☐ No ☐ N/A
9b	Is the MEWA or ECE in compliance with the Mental Health Parity Act of 1996 and the Department's regulations issued thereunder? (See Worksheet B) . . . . . ➤	☐ Yes ☐ No ☐ N/A
9c	Is the MEWA or ECE in compliance with the Newborns' and Mothers' Health Protection Act of 1996 and the Department's regulations issued thereunder? (See Worksheet C) . . . . . ➤	☐ Yes ☐ No ☐ N/A
9d	Is the MEWA or ECE in compliance with the Women's Health and Cancer Rights Act of 1998? (See Worksheet D) . . . . . ➤	☐ Yes ☐ No ☐ N/A

IF MORE SPACE IS REQUIRED FOR ANY ITEM, ATTACH ADDITIONAL SHEETS THE SAME SIZE AS THIS FORM.

Caution: *Penalties may apply in the case of a late or incomplete filing of this report.*

Under penalty of perjury and other penalties set forth in the instructions, I declare that I have examined this report, including any accompanying attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of administrator ➤ _____ Date ➤ _____

Type or print name of administrator ➤ _____

Department of Labor
Pension and Welfare Benefits Administration

Instructions for Form M-1

Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)

ERISA refers to the Employee Retirement Income Security Act of 1974

Paperwork Reduction Act Notice

We ask for the information on this form to carry out the law as specified in ERISA. You are required to give us the information. We need it to determine whether the MEWA or ECE is operating according to law. You are not required to respond to this collection of information unless it displays a current, valid OMB control number.

The average time needed to complete and file the form is estimated below. These times will vary depending on individual circumstances.

Learning about the law or the form	Preparing the form
2 hrs.	50 min. - 1 hr and 35 min.

Contents

The instructions are divided into three main sections.

Section 1 Page
1.1 Introduction 1
1.2 Who Must File 1
1.3 When to File 2
1.4 Where to File 2
1.5 Penalties 2

Section 2
2.1 Year to be Reported 2
2.2 90-Day Origination Report 3
2.3 Signature and Date 3
2.4 Amended Report 3

Section 3
3.1 Line-By-Line Instructions 3
3.2 Voluntary Worksheets 6

SECTION 1

1.1 Introduction

This form is required to be filed under section 101(g){h}* and section 734 of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and 29 CFR 2520.101-2.

The Department of Labor, Pension and Welfare Benefits Administration (PWBA) is committed to working together with administrators to help them comply with this filing requirement. Filer's guides, which may be helpful in filing this report are available by calling the PWBA toll-free publication hotline at 1-800-998-7542 and on the Internet at: http://www.dol.gov/dol/pwba. If you have any questions (such as whether you are required to file this report) or if you need any assistance in completing this report, please call the PWBA help desk at (202) 219-8818.

All Form M-1 reports are subject to a computerized review. It is, therefore, in the filer's best interest that the responses accurately reflect the circumstances they were designed to report.

* Both the Small Business Job Protection Act of 1996 (Pub. L. 104-188) and the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) created a new section 101(g) of ERISA. Accordingly, section 101(g) of ERISA that relates to reporting by certain arrangements is referred to in this document as section 101(g){h} of ERISA.

1.2 Who Must File

General rules

The "administrator" (defined below) of a "multiple employer welfare arrangement" (MEWA, defined below) generally must file this report for every calendar year, or portion thereof, that the MEWA offers or provides benefits for medical care to the employees of two or more employers (including one or more self-employed individuals). The administrator of an "entity claiming exception" (ECE, defined below) must file the report each year for the three years after the ECE is "originated" (defined below). (Warning: An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

However, in no event is reporting required by the administrator of a MEWA or ECE if the MEWA or ECE is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees.

Accordingly, subject to the exception described above for licensed or authorized health insurance issuers, the administrator of a MEWA is required to file annually. By contrast, the administrator of an ECE is required to file for three years following an origination. Whether or not an entity is a MEWA or ECE is determined by the administrator acting in good faith. Therefore, if an administrator makes a good faith determination at the time of the filing that the entity is maintained pursuant to one or more collective bargaining agreements, the entity is an ECE, and the ECE is not required to file because its most recent origination was more than three years ago, then a filing is not required. Even if the entity is later determined to be a MEWA, filings are not required prior to the determination that the entity is a MEWA if at the time the filings were due, the administrator made a good faith determination that the entity was an ECE. However, filings are required for years after the determination that the entity is a MEWA.

In contrast, while an administrator's good faith determination that an entity is an ECE may eliminate the requirement that the administrator of the entity file under this section for more than three years after the entity's origination date, the administrator's determination does not affect the applicability of State law to the entity. Accordingly, incorrectly claiming the exception may eliminate the need to file under this section, if the claiming of the exception is done in good faith. However, the claiming of the exception for ECEs under this filing requirement does not prevent the application of State law to an entity that is later determined to be a MEWA. This is because the filing, or the failure to file, under this section does not in any way affect the application of State law to a MEWA.

Definition of "Administrator"

For purposes of this form, the "administrator" is the person specifically designated by the terms of the MEWA or ECE. However, if the MEWA or ECE is a group health plan and the administrator is not so designated, the plan sponsor (as defined in section 3(16)(B) of ERISA) is the administrator. Moreover, in the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot

be identified, the administrator is the person or persons actually responsible (whether or not so designated under the terms of the MEWA or ECE) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent or trustee designated by such person or persons.

Definition of "Multiple Employer Welfare Arrangement" or "MEWA"
In general, a multiple employer welfare arrangement (MEWA) is an employee welfare benefit plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that the term does not include any such plan or other arrangement that is established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. See ERISA section 3(40).

Definition of "Entity Claiming Exception" or "ECE"
For purposes of this report, the term "entity claiming exception" or "ECE" means any plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, and that claims it is not a MEWA because the plan or other arrangement claims the exception relating to plans established or maintained pursuant to one or more collective bargaining agreements (contained in section 3(40)(A)(i) of ERISA).

The administrator of an ECE must file this report each year for the first three years after the ECE is "originated". (Warning: An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

Definition of "Originated"
For purposes of this report, a MEWA or ECE is "originated" each time any of the following events occur:

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals),

(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECEs (unless all MEWAs or ECEs involved in the transaction have been offering or providing coverage for at least three years prior to the transaction), or

(3) The number of employees to which the MEWA or ECE offers or provides coverage for medical care is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

Therefore, a MEWA or ECE may be originated more than once. Each time an ECE is originated, filings are triggered.

1.3 When to File

General Rule
The administrator of a MEWA or ECE that is required to file must file the Form M-1 no later than March 1 following any calendar year for which a filing is required.

*** Transition Rule for Year 2000 Filings: For the 1999 Year to be Reported, the administrator of a MEWA or ECE that is required to file must file the Form M-1 no later than May 1, 2000.

90-Day Origination Report
In general, an expedited filing is required after a MEWA or ECE is originated. To satisfy this requirement, the administrator must complete and file the Form M-1 within 90 days of the date the MEWA or ECE is originated (unless the last day of the 90-day period is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the following business day).

Exceptions to the 90-Day Origination Report Requirement
(1) No 90-Day Origination Reports are due before May 1, 2000. (Therefore, for an entity that is originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity that is originated, for example, on April 1, 2000, a 90-Day Origination Report is required to be completed and filed no later than June 30, 2000.)

(2) No 90-Day Origination Report is required if the entity was originated in October, November, or December.

Extensions
A one-time extension of time to file will automatically be granted if the administrator of the MEWA or ECE requests an extension. To request an extension, the administrator must complete and file Parts I and II of the Form M-1 (and check **Box B(3)** in Part I) no later than the normal due date for the report. In such a case, the administrator will have an additional 60 days to file a completed Form M-1. A copy of the request for extension must be attached to the completed Form M-1 when filed.

1.4 Where to File

Completed copies of the Form M-1 should be sent to:

Public Documents Room, Pension and Welfare Benefits Administration
Room N-5638, U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, DC 20210

1.5 Penalties

Good Faith Safe Harbor for Filings Due in Year 2000. The Department of Labor, Pension and Welfare Benefits Administration is committed to working together with administrators to help them comply with this filing requirement. In this regard, the Department does not intend to assess penalties in cases where there has been a good faith effort to comply with a filing due in the Year 2000.

However, in instances where there has not been a good faith effort to comply with a filing due in the Year 2000, and for any filing due after the Year 2000 (whether or not the administrator has made a good faith effort to comply), please be aware that ERISA provides for the assessment or imposition of a penalty for failure to file a report, failure to file a completed report, and late filings. In the event of no filing, an incomplete filing, or a late filing, a penalty may apply of up to $1,000 a day for each day that the administrator of the MEWA or ECE fails or refuses to file a complete report. In addition, certain other penalties may apply.

SECTION 2

2.1 Year to be Reported

General rule
The administrator of a MEWA or ECE that is required to file should complete the form using the previous calendar year's information. (Thus, for example, for a filing that is due by May 1, 2000, calendar year 1999 information should be used.)

Fiscal year exception
The administrator of a MEWA or ECE that is required to file may report using fiscal year information if the administrator of the MEWA or ECE has at least six continuous months of fiscal year information to report. (Thus, for example, for a filing that is due by May 1, 2000, fiscal year 1999 information may be used if the administrator has at least six continuous months of fiscal year 1999 information to report.) In this case, the administrator should check **Box A(2)** and specify the fiscal year.

2.2 The 90-Day Origination Report

When a MEWA or ECE is originated, a 90-Day Origination Report is generally required. (See section 1.3 on When to File). When filing a 90-Day Origination Report, the administrator is required to complete the Form M-1 using information based on at least 60 continuous days of operation by the MEWA or ECE.

Remember, there are two exceptions to the 90-Day Origination Report requirement: (1) No 90-Day Origination Reports are due before May 1, 2000. (Nonetheless, for an entity that is originated, for example, on April 1, 2000, a 90-Day Origination Report is required to be completed and filed by June 30, 2000.); and (2) No 90-Day Origination Report is required if the entity was originated in October, November, or December.

2.3 Signature and Date

The administrator must sign and date the report. The signature must be original. The name of the individual who signed as the administrator must be typed or printed clearly on the line under the signature line.

2.4 Amended Report

To correct errors and/or omissions on a previously filed Form M-1, submit a completed Form M-1 with Part I, **Box B(2)** checked and an original signature. When filing an amended report, answer all questions and circle the amended line numbers.

SECTION 3

Important: "Yes/No" questions must be marked "Yes" or "No," but not both. "N/A" is not an acceptable response unless expressly permitted in the instructions to that line.

3.1 Line-By-Line Instructions

Part I - Annual Report Identification Information
Complete either **Item A** or **Item B**, as applicable.

Item A: If this is an annual report, check either box A(1) or box A(2).
Check **box A(1)** if calendar year information is being used to complete this report. (See Section 2.1 on Year to be Reported.)
Check **box A(2)** if fiscal year information is being used to complete this report. Also specify the fiscal year. (For example, if fiscal year 1999 information is being used instead of calendar year 1999 information, specify the date the fiscal year begins and ends.) (See Section 2.1 on Year to be Reported.)

Item B: If this is a special filing, check either box B(1), box B(2), or box (B)(3).
Check **box B(1)** if this form is a 90-Day Origination Report. (See Section 1.2 on Who Must File, Section 1.3 on When to File, and Section 2.2 on 90-Day Origination Reports.)
Check **box B(2)** if this form is an Amended Report. (See Section 2.4 on Amended Reports.)
Check **box B(3)** if the administrator of the MEWA or ECE is requesting an extension. (See Section 1.3 on When to File.)

Part II - MEWA or ECE Identification Information

Items 1a through 1d: Enter the name and address of the MEWA or ECE, the telephone number of the MEWA or ECE, and any employer identification number (EIN) and plan number (PN) used by the MEWA or ECE in reporting to the Department of Labor or the Internal Revenue Service. If the MEWA or ECE does not have any EINs associated with it, leave **Item 1c** blank. If the MEWA or ECE does not have any PNs associated with it, leave **Item 1d** blank. In answering these questions, list only EINs and PNs used by the MEWA or ECE itself and not by group health plans or employers that purchase coverage through the MEWA or ECE.

Items 2a through 2c: Enter the name and address of the administrator of the MEWA or ECE, the telephone number of the administrator, and any employer identification number (EIN) used by the administrator in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the administrator as a separate entity. Do not use any EIN associated with the MEWA or ECE itself.

Items 3a through 3c: Enter the name and address of the entity sponsoring the MEWA or ECE, the telephone number of the sponsor, and any employer identification number (EIN) used by the sponsor in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the sponsor. Do not use any EIN associated with the MEWA or ECE itself. If the MEWA or ECE is a group health plan, the sponsor is the "plan sponsor," which is defined in ERISA section 3(16)(B) as (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. If the MEWA or ECE is not a group health plan, the administrator should enter the name, address, or telephone number of the entity that establishes or maintains the MEWA or ECE. If there is no such entity, leave **Item 3** blank and skip to **Item 4**.

Part III - Registration Information

Item 4: Enter the date the MEWA or ECE was most recently "originated." For this purpose, a MEWA or ECE is "originated" each time any of the following events occur:
(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);
(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECEs (unless all MEWAs or ECEs involved in the transaction have been offering or providing coverage for at least three years prior to the transaction); or
(3) The number of employees to which the MEWA or ECE offers or provides coverage for medical care is at least 50 percent greater than the number of such employees during the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

Item 5: Complete the chart. If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with

information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Item 5a. Under **Item 5a**, enter all States in which the MEWA or ECE offers or provides benefits for medical coverage.

In answering this question, a "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

Item 5b. Under **Item 5b**, specify whether the MEWA or ECE is licensed or otherwise authorized to operate as a health insurance issuer in each such State. (A "health insurance issuer" is defined, in pertinent part, in § 2590.701-2 of the Department's regulations, "an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law which regulates insurance . . . . Such term does not include a group health plan.")

Item 5c. If the answer to Item 5b is "yes," under **Item 5c**, enter the National Association of Insurance Commissioners (NAIC) number.

Item 5d. If the answer to Item 5b is "no," under **Item 5d** specify whether the MEWA or ECE is fully-insured by a health insurance issuer in each State.

Item 5e. If the answer to Item 5d is "yes," under **Item 5e** enter the name of the insurer and its NAIC number.

Item 5f. Under **Item 5f**, specify whether the MEWA or ECE has purchased any stop-loss coverage. For this purpose, stop-loss coverage includes any coverage defined by the State as stop-loss coverage. For this purpose, stop-loss coverage also includes any financial reimbursement instrument that is related to liability for the payment of health claims by the MEWA or ECE, including reinsurance.

Item 5g. If the answer to Item 5f is "yes," under **Item 5g** enter the name of the stop-loss insurer and its NAIC number.

If more space is needed to complete **Item 5**, additional pages may be attached. These pages must indicate "Item 5 Attachment" in the upper right corner and must be in a format similar to that of **Item 5**.

Item 6: Of the States identified in **Item 5a**, identify all States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

For example, consider a MEWA that offers or provides coverage to the employees of six employers. Two employers are located in State X and 70 employees of the two employers receive coverage through the MEWA. Three employers are located in State Y and 30 employees of the three employers receive coverage through the MEWA. Finally, one employer is located in State Z and 200 employees of the employer receive coverage through the MEWA. In this example, the administrator of the MEWA should specify State X and State Z under Item 6 because the MEWA conducts 23⅓% of its business in State X (70÷300 = 23⅓%) and 66⅔% of its business in State Z (200÷300 = 66⅔%). However, the administrator should not specify State Y because the MEWA conducts only 10% of its business in State Y (30÷300 = 10%)

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Item 7: Identify the total number of participants eligible to receive coverage for benefits under the MEWA or ECE.

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Part IV - Information for Compliance with Part 7 of ERISA

Background Information on Part 7 of ERISA: On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. On September 26, 1996, both the Mental Health Parity Act of 1996 (MHPA) and the Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act) were enacted. On October 21, 1998, the Women's Health and Cancer Rights Act of 1998 (WHCRA) was enacted. All of the foregoing laws amended Part 7 of ERISA with new requirements for group health plans. With respect to most of these requirements, corresponding provisions are contained in Chapter 100 of Subtitle K of the Internal Revenue Code (Code) and Title XXVII of the Public Health Service Act (PHS Act). These provisions generally are substantively identical.

The Departments of Labor, the Treasury, and Health and Human Services first issued interim final regulations implementing HIPAA's portability, access, and renewability provisions on April 1, 1997 (published in the Federal Register on April 8, 1997, 62 FR 16893). Two clarifications of the HIPAA regulations were published in the Federal Register on December 29, 1997 at 62 FR 67687. Regulations implementing the MHPA provisions were published in the Federal Register on December 22, 1997 at 62 FR 66931. Also, regulations implementing the substantive provisions of Newborns' Act were published in the Federal Register on September 9, 1998 at 63 FR 48372 and on October 27, 1998 at 63 FR 57545. Moreover, the notice requirements with respect to group health plans that provide coverage for maternity or newborn infant coverage are described in the Department's summary plan description (SPD) content regulations at 29 CFR 2520.102-3(u), 63 FR 48372 (September 9, 1998). Finally, on November 23, 1998, the Department issued informal guidance on WHCRA in the form of questions and answers. All of the above-mentioned guidance is available on the Department's website at www.dol.gov/dol/pwba and via the Pension and Welfare Benefits Administration's toll-free publications hotline at 1-800-998-7542.

General Information Regarding the Applicability of Part 7: In general, the foregoing provisions apply to group health plans and health insurance issuers in the group market. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. A health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance. Such term does not include a group health plan. Group market generally means the market for health insurance coverage offered in connection with a group health plan.

Many MEWAs and ECEs are group health plans or health insurance issuers. However, even if the MEWA or ECE is neither a group health plan nor a health insurance issuer, if the MEWA or ECE offers or provides coverage in the group market, the coverage is required to comply with Part 7 of ERISA.

Relation to Other Laws:
States may, under certain circumstances, impose stricter laws with respect to health insurance issuers. Generally, questions concerning State laws should be directed to the State Insurance Commissioner's Office.

For More Information: To obtain copies of the Department of Labor's booklet, "Questions and Answers: Recent Changes in Health Care Law," which includes information on HIPAA, MHPA, the Newborns' Act, and WHCRA, you may call the Department's toll-free publication hotline at 1-800-998-7542. This booklet is also available on the Internet at : www.dol.gov/dol/pwba. If you have any additional questions concerning Part 7 of ERISA, you may call the Department of Labor office nearest you or the Department's health care question hotline at 202-219-8776.

Items 8a and 8b: With respect to **Item 8a**, check "yes" or "no" as applicable. For this purpose, do not include any audit that does not result in required corrective action. If you answer "yes" under **Item 8a**, identify, in **Item 8b,** any such litigation or enforcement proceeding. If you need more space, you may attach additional pages. These pages must read "Item 8b Attachment" in the upper right corner.

Item 9a: The portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) comprise sections 701, 702, and 703 of ERISA, sections 9801, 9802, and 9803 of the Internal Revenue Code of 1986 (Code), and sections 2701 and 2702 of the Public Health Service Act (PHS Act).

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Similarly, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet A may be helpful.

Item 9b: The Mental Health Parity Act of 1996 (MHPA) provisions are in section 712 of ERISA, section 9812 of the Code, and section 2705 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Second, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Third, if you are the administrator of a MEWA or ECE that does not provide both medical/surgical benefits and mental health benefits, you may answer "N/A." Finally, if you are the administrator of a MEWA or ECE that offers or provides coverage only to small employers (as described in the small employer exemption contained section 712(c)(1) of ERISA and § 2590.712(e) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder) or if the coverage satisfied the requirements for the increased cost exemption (described in section 712(c)(2) of ERISA and § 2590.712(f) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet B may be helpful.

Item 9c: The Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act) provisions are in section 711 of ERISA, section 9811 of the Code, and section 2704 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A."

Moreover, if you are the administrator of a MEWA or ECE that does not provide benefits for hospital lengths of stay in connection with childbirth, you may answer "N/A." Finally, if you are the administrator of a MEWA or ECE that is subject to State law regulating such coverage, instead of the federal Newborns' Act requirements, in all States identified in **Item 5a**, in accordance with section 711(f) of ERISA and § 2590.711(e) of the Department's regulations (and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet C may be helpful.

Item 9d: The Women's Health and Cancer Rights Act of 1998 (WHCRA) provisions are in section 713 of ERISA and section 2706 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the PHS Act and the regulations issued thereunder), you may answer "N/A." Similarly, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Lastly, if you are the administrator of a MEWA or ECE that does not provide medical/surgical benefits with respect to a mastectomy, you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet D may be helpful.

3.2 Voluntary Worksheets

Voluntary worksheets, which may be used to help assess an entity's compliance with Part 7 of ERISA, are included on the following pages of these instructions. These worksheets may also be helpful in answering **Items 9a** through **9d** of the Form M-1.

Worksheet A (Form M-1)	**Determining Compliance with the HIPAA Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the HIPAA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to any of the questions below, you should review your entity's operations because the entity may not be in full compliance with the HIPAA provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) Does the MEWA or ECE issue certificates of creditable coverage automatically to individuals who lose coverage under the MEWA or ECE and to individuals upon request? ..... ➤ ☐ Yes ☐ No

- Section 701(e) of ERISA and § 2590.701-5 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) require group health plans and group health insurance issuers to issue, free of charge, certificates of creditable coverage automatically to individuals who lose coverage and to any individual upon request.
- In the case of a certificate issued automatically, the certificate should reflect the most recent continuous period of creditable coverage. In the case of a certificate issued upon request, the certificate should reflect all creditable coverage that the individual had in the 24 months prior to the date of request. However, in no event is a certificate required to reflect more than 18 months of creditable coverage.
- Most health coverage is creditable coverage. However, coverage consisting solely of excepted benefits is not creditable coverage. Examples of benefits that may be excepted benefits include limited-scope dental benefits, limited-scope vision benefits, hospital indemnity benefits, and Medicare supplemental benefits.
- If you have a question whether health coverage offered by a MEWA or ECE is creditable coverage or is coverage consisting solely of excepted benefits, contact the Department of Labor office nearest you or call the Department's health care question hotline at 202-219-4377. This is not a toll-free number.

(2) Has the MEWA or ECE made available a procedure for individuals to request and receive certificates? ..... ➤ ☐ Yes ☐ No

- Section 2590.701-5(a)(4)(ii) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires group health plans and group health insurance issuers to establish a procedure for individuals to request and receive certificates.

(3) If the MEWA or ECE imposes a preexisting condition exclusion period, does it issue a notice informing individuals of the exclusion, the terms of the exclusion, and the right of individuals to demonstrate creditable coverage to reduce the period of the exclusion? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 2590.701-3(c) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires that a group health plan, and a group health insurance issuer, may not impose a preexisting condition exclusion with respect to a participant or a dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage.
- The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(4) If the MEWA or ECE imposes a preexisting condition exclusion period, does it issue letters of determination and notification of creditable coverage within a reasonable time after the receipt of individuals' creditable coverage information? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 2590.701-5(d) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) states that, within a reasonable time following receipt of evidence of creditable coverage, a plan or issuer seeking to impose a preexisting condition exclusion with respect to an individual is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied.

- In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage.

(5) If the MEWA or ECE imposes a preexisting condition exclusion period, does it comport with HIPAA's limitations on preexisting condition exclusion periods? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 701(a)(1) of ERISA and § 2590.701-3(a)(1)(i) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a plan or issuer may impose a preexisting condition exclusion period only if it relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the individual's enrollment date in the plan or coverage. (Therefore, genetic information is not treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.) The enrollment date, for purposes of the HIPAA limitations on preexisting condition exclusion periods, is the first day of coverage or, if there is a waiting period, the first day of the waiting period. (For health insurance issuers, State law may prescribe a shorter period than the 6-month period that generally applies.)

- Section 701(a)(2) of ERISA and section § 2590.701-3(a)(1)(ii) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that any preexisting condition exclusion period is limited to 12 months (18 months for late enrollees) after an individual's enrollment date in the plan or coverage. (For health insurance issuers, State law may prescribe a shorter period.)

- Section 701(a)(3) of ERISA and § 2590.701-3(a)(1)(iii) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that any preexisting condition exclusion period is reduced by the number of days of an individual's creditable coverage prior to his or her enrollment date.

- When determining the number of days of creditable coverage, the plan or issuer is not required to take into account any days that occur prior to a significant break in coverage. The federal law defines a significant break in coverage as a break of 63 days or more. However, State law applicable to health insurance coverage offered or provided by health insurance issuers may provide for a longer period.

- In any case, section 701(d) of ERISA and § 2590.701-3(b) provide that a group health plan, and a group health insurance issuer, may not impose any preexisting condition exclusion period with regard to a child who enrolls in a group heath plan within 30 days of birth, adoption, or placement for adoption and who does not incur a subsequent significant break in coverage. In addition, a group health plan, and a group health insurance issuer, may not impose a preexisting condition exclusion relating to pregnancy. (For health insurance issuers, State law may further restrict the extent to which a preexisting condition exclusion may be imposed.)

(6) Does the MEWA or ECE issue notices of special enrollment rights to individuals who are eligible to enroll in the plan or coverage? ..... ➤ ☐ Yes ☐ No

- Section 2590.701-6(c) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires that, on or before the time an employee is offered the opportunity to enroll in a group health plan or coverage, the plan or issuer provide the employee with a description of the plan's special enrollment rules.

- For this purpose, the plan may use the following model description of special enrollment rules:

  If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(7) Does the MEWA or ECE provide special enrollment rights to individuals who lose other coverage and to individuals who acquire a new dependent, if they request enrollment within 30 days of the loss of coverage, marriage, birth, adoption, or placement for adoption? ..... ➤ ☐ Yes ☐ No

- Section 701(f) of ERISA and § 2590.701-6 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) require group health plans, and group health insurance issuers, if certain conditions are met, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the individual loses other coverage or acquires a new dependent through marriage, birth, adoption, or placement for adoption.

- For State laws applicable to health insurance issuers that may provide individuals with additional special enrollment rights, check with an attorney or the Insurance Commissioner's Office in your State.

(8) Do the MEWA's or ECE's rules for eligibility (including continued eligibility) comply with the nondiscrimination requirements that prohibit discrimination against any individual or a dependent of an individual based on any health factor? ..... ➤ ☐ Yes ☐ No

- Section 702(a) of ERISA and § 2590.702(a) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a group health plan, and a group health insurance issuer, may not establish rules for eligibility (including continued eligibility, rules defining any applicable waiting periods, and rules relating to late and special enrollment) of any individual to enroll under the terms of the plan based on a health factor.

- The health factors are: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

- However, nothing requires a plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the plan or coverage. In addition, nothing prevents a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(9) Does the MEWA or ECE comply with the nondiscrimination requirements that prohibit requiring any individual (as a condition of enrollment or continued enrollment) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor? ..... ➤ ☐ Yes ☐ No

- Section 702(b) of ERISA and § 2590.702(b) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a group health plan, and a group health insurance issuer, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor (defined above).

- However, nothing restricts the amount that an employer may be charged for coverage under a group health plan and nothing prevents a plan or issuer from establishing premium discounts or rebates or modifying applicable copayments or deductibles in return for adherence to bona fide wellness programs.

(10) If the entity is a multiemployer plan or a MEWA, does it comply with the guaranteed renewability requirements, which generally prohibit it from denying an employer whose employees are covered under a group health plan continued access to the same or different coverage under the terms of the plan? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 703 of ERISA (as well as the corresponding provisions in the Code) provides that a group health plan that is a multi-employer plan or a MEWA may not deny an employer whose employees are covered under the plan continued access to the same or different coverage under the terms of the plan, other than for nonpayment of contributions; for fraud or other intentional misrepresentation of material fact by the employer; for noncompliance with material plan provisions; because the plan is ceasing to offer any coverage in a geographic area; in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan acts without regard to the claims experience of the employer or any health factor in relation to those individuals or their dependents; and for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

- For other laws applicable to health insurance issuers that may provide additional guaranteed renewability requirements, check with an attorney or the Insurance Commissioner's Office in your State.

Worksheet B (Form M-1)	Determining Compliance with the Mental Health Parity Act (MHPA) Provisions in Part 7 of Subtitle B of Title I of ERISA Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the MHPA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the question below, you should review your entity's operations because the entity may not be in full compliance with the MHPA provisions in Part 7 of ERISA. If you need help answering this question or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

Q. If the MEWA or ECE offers or provides both mental health benefits and medical/surgical benefits, does the MEWA or ECE comply with the requirements of the MHPA provisions, which are contained in section 712 of ERISA (as well as the corresponding provisions of the Code and the PHS Act)? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 712 of ERISA and § 2590.712 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) generally provide for parity in the application of aggregate lifetime dollar limits and in the application of annual dollar limits between benefits for medical and surgical care and benefits for mental health coverage.
- However, these provisions do not require a group health plan or group health insurance coverage to provide any mental health coverage. And, MHPA does not apply to benefits for substance abuse or chemical dependency.
- In addition, there are exemptions for small employers and certain plans or coverage with increased costs.
- Finally, MHPA does not apply to benefits for services furnished on or after September 30, 2001.
- Contact the Department of Labor Office nearest you or call the Department's health care hotline at 202-219-4377 to find out more about these provisions.

Worksheet C (Form M-1)	**Determining Compliance with the Newborns' and Mothers' Health Protection Act (Newborns' Act) Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the Newborns' Act provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the questions below, you should review your entity's operations because the entity may not be in full compliance with the Newborns' Act provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) If the MEWA or ECE offers or provides benefits for hospital stays in connection with childbirth and is subject to the Newborns' Act, does the MEWA or ECE comply with the Newborns' Act's substantive requirements, which are contained in section 711 of ERISA (as well as the corresponding provisions of the Code and the PHS Act)? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 711 of ERISA and § 2590.711 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) generally provide that a group health plan, and a group health insurance issuer, that offers benefits for hospital lengths of stay in connection with childbirth may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or her newborn child, following a vaginal delivery to less than 48 hours, and following a cesarean section to less than 96 hours, unless the attending provider, in consultation with the mother, decides to discharge earlier.

- In addition, such a plan or issuer may not require that the provider obtain authorization from the plan or issuer for prescribing any length of hospital stay up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section. Nor may such a plan or issuer penalize an attending provider for complying with this law or provide incentives to an attending provider to provide care in a manner that is inconsistent with this law. Nor may such a plan or issuer deny the mother or newborn eligibility or continued eligibility, or provide incentives to mothers to encourage them to accept less than the minimum length of stay required. Nor may such a plan or issuer restrict benefits for any portion of a period within a hospital length of stay required by this law in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

- The Newborns' Act's requirements apply to all self-insured benefits offered in connection with childbirth. However, State law rather than federal law may apply to health insurance coverage offered in connection with childbirth if the State law meets certain criteria specified in section 711(d) of ERISA and § 2590.711(d) of the Department's regulations. (These criteria are also specified in the Code and the PHS Act and the regulations issued thereunder.) Based on a preliminary review of State laws as of July 1, 1998, State law rather than federal law applies to health insurance coverage offered in connection with childbirth in the following States:

  Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and West Virginia. Health insurance coverage offered in connection with childbirth in other States should also comply with the federal Newborns' Act requirements.

  Moreover, the following States appear to have a State law applicable to health insurance coverage that references the federal Newborns' Act provisions:

  Delaware, Idaho, and Oregon.

  Finally, the following States and other jurisdictions do not appear to have a law regulating coverage for newborns and mothers that would apply to health insurance coverage. Therefore, the federal Newborns' Act provisions appear to apply to health insurance coverage in the following States:

  Hawaii, Michigan, Mississippi, Nebraska, Utah, Vermont, Wisconsin, Wyoming, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

(2) If the MEWA or ECE or provides benefits in connection with childbirth and is a group health plan, does the MEWA or ECE comply with the disclosure requirements under the Newborn's Act? ..... ➤ ☐ Yes ☐ No ☐ N/A

- Section 711(d) of ERISA and § 2520.102-3(u) require group health plans providing maternity benefits to include a statement in their summary plan descriptions advising individuals of the Newborns' Act's requirements.

- For this purpose, a MEWA or ECE that is subject to the Newborns' Act disclosure requirements through ERISA may use the following sample language:

  > 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 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 the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- MEWAs and ECEs that are nonfederal governmental plans are subject to a similar disclosure requirement. For mandated language required to be used by such plans, see 45 CFR § 146.130(d)(2) (published in the **Federal Register** at 63 CFR 57561 on October 27, 1998).

Worksheet D (Form M-1)	**Determining Compliance with the Women's Health and Cancer Rights Act (WHCRA) Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	OMB No. 1210-xxxx Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the WHCRA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the questions below, you should review your entity's operations because the entity may not be in full compliance with the WHCRA provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) If the MEWA or ECE offers or provides mastectomy coverage, does the MEWA or ECE comply with WHCRA's substantive requirements, which are contained in section 713 of ERISA (as well as the corresponding provisions of the PHS Act)? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 713 of ERISA (as well as the corresponding provisions in the PHS Act) generally provides that a group health plan, and a group health insurance issuer, that offers mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- In addition, a plan or issuer may not deny a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of WHCRA. Nor may a plan or issuer penalize or otherwise reduce or limit the reimbursement of an attending provider; or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to furnish care to an individual participant or beneficiary in a manner inconsistent with WHCRA.
- Plans and issuers may impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.
- State law protections may apply to certain health insurance coverage if the State law was in effect on October 21, 1998 (the date of enactment of WHCRA) and the State law requires at least the coverage for reconstructive breast surgery that is required by WHCRA.

(2) If the MEWA or ECE offers or provides mastectomy coverage, does the MEWA or ECE comply with the disclosure requirements under WHCRA? . . . . . ➤ ☐ Yes ☐ No ☐ N/A

- Section 713(b) of ERISA (as well as the corresponding provisions of the PHS Act) establishes a one-time notice requirement under which group health plans, and their health insurance issuers, must furnish a written description of the benefits that WHCRA requires. This notice is required to be furnished as part of the next general mailing (made after October 21, 1998) by group health plans, and their health insurance issuers, or in the yearly information packet sent out regarding the plan, but, in any event, the one-time notice is required to be furnished not later than January 1, 1999.
- Section 713(a)(3) of ERISA (as well as the corresponding provisions of the PHS Act) establishes a disclosure requirement under which group health plans, and their health insurance issuers, must again describe the benefits required under WHCRA, but the notice is to be provided upon enrollment in the plan and annually thereafter.
- Both notices must indicate that, in the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. The notice must also describe any deductibles and coinsurance limitations applicable to such coverage. (Under WHCRA, coverage of breast reconstruction benefits may be subject to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.)

[65 FR 7163, Feb. 11, 2000]

Subpart B—Contents of Plan Descriptions and Summary Plan Descriptions

§ 2520.102–1 [Reserved]

§ 2520.102–2 Style and format of summary plan description.

(a) *Method of presentation.* The summary plan description shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan's participants and beneficiaries of their rights and obligations under the plan. In fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents.

(b) *General format.* The format of the summary plan description must not have the effect to misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.

(c) *Foreign languages.* In the case of either—

(1) A plan that covers fewer than 100 participants at the beginning of a plan year, and in which 25 percent or more of all plan participants are literate only in the same non-English language, or

(2) A plan which covers 100 or more participants at the beginning of the plan year, and in which the lesser of (i) 500 or more participants, or (ii) 10% or more of all plan participants are literate only in the same non-English language, so that a summary plan description in English would fail to inform these participants adequately of their rights and obligations under the plan, the plan administrator for such plan shall provide these participants with an English-language summary plan description which prominently displays a notice, in the non-English language common to these participants, offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants the procedures they must follow in order to obtain such assistance.

Example. Employer A maintains a pension plan which covers 1000 participants. At the beginning of a plan year five hundred of Employer A's covered employees are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining 399 are literate in English. Each of the 1000 employees receives a summary plan description in English, containing an assistance notice in both Spanish and Vietnamese stating the following:

''This booklet contains a summary in English of your plan rights and benefits under Employer A Pension Plan. If you have difficulty understanding any part of this booklet, contact Mr. John Doe, the plan administrator, at his office in Room 123, 456 Main St., Anywhere City, State 20001. Office hours are from 8:30 A.M. to 5:00 P.M. Monday through Friday. You may also call the plan administrator's office at (202) 555–2345 for assistance.''

[42 FR 37180, July 19, 1977]

§ 2520.102–3 Contents of summary plan description.

Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of the date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

(a) The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;

(b) The name and address of—

(1) In the case of a single employer plan, the employer whose employees are covered by the plan,

(2) In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan,

(3) In the case of a collectively-bargained plan established or maintained by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, parent or most significantly employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b–1 and 2520.104b–30; or

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

(4) In the case of a plan established or maintained by two or more employers, the association, committee, joint board of trustees, parent or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b–1 and 2520.104b–30, or,

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.

(c) The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor. (For further detailed explanation, see the instructions to the plan description Form EBS–1 and ''Identification Numbers Under ERISA'' (Publ. 1004), published jointly by DOL, IRS, and PBGC);

(d) The type of pension or welfare plan, e.g. pension plans—defined benefit, defined contribution, 401(k), cash balance, money purchase, profit sharing, ERISA section 404(c) plan, etc., and for welfare plans—group health plans, disability, pre-paid legal services, etc.

(e) The type of administration of the plan, e.g., control administration, insurer administration, etc.;

(f) The name, business address and business telephone number of the plan administrator as that term is defined by section 3(16) of the Act;

(g) The name of the person designated as agent for service of legal process, and the address at which process may be served on such person, and in addition, a statement that service of legal process may be made upon a plan trustee or the plan administrator;

(h) The name, title and address of the principal place of business of each trustee of the plan;

(i) If a plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b–1 and 2520.104b–30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;

(j) The plan's requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan's provisions relating to eligibility to participate in the plan and the information identified in paragraphs (j)(1), (2) and (3) of this section, as appropriate.

(1) For employee pension benefit plans, it shall also include a statement describing the plan's normal retirement age, as that term is defined in section 3(24) of the Act, and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits. Such plan benefits shall be described or summarized. In addition, the summary plan description shall include a description of the procedures governing qualified domestic relations order (QDRO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

(2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. In the case of a welfare plan providing extensive schedules of benefits (a group health plan, for example), only a general description of such benefits is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests. In addition, the summary plan description shall include a description of the procedures governing qualified medical child support order (QMCSO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

(3) For employee welfare benefit plans that are group health plans, as defined in section 733(a)(1) of the Act, the summary plan description shall include a description of: any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of speciality medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan's SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically, without charge, as a separate document.

(k) In the case of an employee pension benefit plan, a statement describing any joint and survivor benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity;

(l) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. In addition to other required information, plans must include a summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated; a summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination of the plan or amendment or elimination of benefits under the plan, including, in the case of an employee pension benefit plan, a summary of any provisions relating to the accrual and the vesting of pension benefits under the plan upon termination; and a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination. Plans also shall include a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan. The foregoing summaries shall be disclosed in accordance with the requirements under 29 CFR 2520.102–2(b).

(m) For an employee pension benefit plan the following information:

(1) If the benefits of the plan are not insured under title IV of the Act, a statement of this fact, and reason for the lack of insurance; and

(2) If the benefits of the plan are insured under title IV of the Act, a statement of this fact, a summary of the pension benefit guaranty provisions of title IV, and a statement indicating that further information on the provisions of title IV can be obtained from the plan administrator or the Pension Benefit Guaranty Corporation. The address of the PBGC shall be provided.

(3) A summary plan description for a single-employer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) nonpension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005–4026 or call 202–326–4000 (not a toll-free number). TTY/TDD users may call the federal relay service

toll-free at 1–800–877–8339 and ask to be connected to 202–326–4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

(4) A summary plan description for a multiemployer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry.

Under the multiemployer plan program, the PBGC provides financial assistance through loans to plans that are insolvent. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC's guaranteed benefit limit) when due.

The maximum benefit that the PBGC guarantees is set by law. Under the multiemployer program, the PBGC guarantee equals a participant's years of service multiplied by (1) 100% of the first $5 of the monthly benefit accrual rate and (2) 75% of the next $15. The PBGC's maximum guarantee limit is $16.25 per month times a participant's years of service. For example, the maximum annual guarantee for a retiree with 30 years of service would be $5,850.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan becomes insolvent; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law; (2) benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the earlier of: (i) The date the plan terminates or (ii) the time the plan becomes insolvent; (3) benefits that are not vested because you have not worked long enough; (4) benefits for which you have not met all of the requirements at the time the plan becomes insolvent; and (5) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Technical Assistance Division, 1200 K Street, N.W., Suite 930, Washington, D.C. 20005–4026 or call 202–326–4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at http://www.pbgc.gov.

(n) In the case of an employee pension benfit plan, a description and explanation of the plan provisions for determining years of service for eligibility to participate, vesting, and breaks in service, and years of participation for benefit accrual. The description shall state the service required to accrue full benefits and the manner in which accrual of benefits is prorated for employees failing to complete full service for a year.

(o) In the case of a group health plan, within the meaning of section 607(1) of the Act, subject to the continuation coverage provisions of Part 6 of Title I of ERISA, a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.

(p) The sources of contributions to the plan—for example, employer, employee organization, employees—and the method by which the amount of contribution is calculated. Defined benefit pension plans may state without further explanation that the contribution is actuarially determined.

(q) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall identify any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided. If a health insurance issuer, within the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

(r) The date of the end of the year for purposes of maintaining the plan's fiscal records;

(s) The procedures governing claims for benefits (including procedures for obtaining preauthorizations, approvals, or utilization review decisions in the case of group health plan services or benefits, and procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any plan), applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act). The plan's claims procedures may be furnished as a separate document that accompanies the plan's SPD, provided that the document satisfies the style and format requirements of 29 CFR 2520.102–2 and, provided further that the SPD contains a statement that the plan's claims procedures are furnished automatically, without charge, as a separate document.

(t)(1) The statement of ERISA rights described in section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of paragraph (t)(2) of this section. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement shall not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of typical participants in the plan and the complexity of the items required under this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so. The summary plan description may state that the statement of ERISA rights is required by Federal law and regulation.

(2) A summary plan description will be deemed to comply with the requirements of paragraph (t)(1) of this section if it includes the following statement; items of information which are not applicable to a particular plan should be deleted:

As a participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age * * *) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may

have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called ''fiduciaries'' of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

(u)(1) For a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the different areas and the federal or state law requirements applicable in each.

(2) In the case of a group health plan subject to section 711 of the Act, the summary plan description will be deemed to have complied with paragraph (u)(1) of this section relating to the required description of federal law requirements if it includes the following statement in the summary plan description:

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 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(Approved by the Office of Management and Budget under control number 1210–0039)

[42 FR 37180, July 19, 1977, as amended at 62 FR 16984, Apr. 8, 1997; 62 FR 31695, June 10, 1997; 62 FR 36205, July 7, 1997; 63 FR 48375, Sept. 9, 1998; 65 FR 70241, Nov. 21, 2000; 66 FR 34994, July 2, 2001; 66 FR 36368, July 11, 2001]

§ 2520.102–4 Option for different summary plan descriptions.

In some cases an employee benefit plan may provide different benefits for various classes of participants and beneficiaries. For example, a plan amendment altering benefits may apply to only those participants who are employees of an employer when the amendment is adopted and to employees who later become participants, but not to participants who no longer are employees when the amendment is adopted. (See § 2520.104b–4). Similarly, a plan may provide for different benefits for participants employed at different plants of the employer, or for different classes of participants in the same plant. In such cases the plan administrator may fulfill the requirement to furnish a summary plan description to participants covered under the plan and beneficiaries receiving benefits under the plan by furnishing to each member of each class of participants and beneficiaries a copy of a summary plan description appropriate to that class. Each summary plan description so prepared shall follow the style and format prescribed in § 2520.102–2, and shall contain all information which is required to be contained in the summary plan description under § 2520.102–3. It may omit information which is not applicable to the class of participants or beneficiaries to which it is furnished. It should also clearly identify on the first page of the text the class of participants and beneficiaries for which it has been prepared and the plan's coverage of other classes. If the classes which the employee benefit plan covers are too numerous to be listed adequately on the first page of the text of the summary plan description, they may be listed elsewhere in the text so long as the first page of the text contains a reference to the page or pages in the text which contain this information.

[67 FR 775, Jan. 7, 2002]

Subpart C—Annual Report Requirements

SOURCE: 43 FR 10140, Mar. 10, 1978, unless otherwise noted.

§ 2520.103–1 Contents of the annual report.

(a) *General.* The administrator of a plan required to file an annual report in accordance with section 104(a)(1) of the Act shall include with the annual report the information prescribed in paragraph (a)(1) of this section or in the limited exemption or alternative method of compliance described in paragraph (a)(2) of this section.

(1) The annual report shall contain the information prescribed in section 103 of the Act.

(2) Under the authority of sections 104(a)(3) and 110 of the Act, a limited exemption or alternative method of compliance is prescribed for employee welfare and pension benefit plans, respectively, which cover 100 or more participants at the beginning of the plan year. A plan electing the limited exemption or alternative method of compliance shall file an annual report containing the information prescribed in paragraph (b) of this section and shall furnish a summary annual report as prescribed in § 2520.104b–10.

(b) *Contents of the annual report for plans with 100 or more participants electing the limited exemption or alternative method of compliance.* Except as provided in paragraph (d) of this section and in §§ 2520.103–2 and 2520.104–44, the annual report of an employee benefit plan covering 100 or more participants at the beginning of the plan year which elects the limited exemption or alternative method of compliance described in paragraph (a)(2) of this section shall include:

(1) A Form 5500 ''Annual Return/Report of Employee Benefit Plan'' and any statements or schedules required to be attached to the form, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule B (Actuarial Information), Schedule C (Service Provider Information), Schedule D (DFE/Participating Plan Information), Schedule G (Financial Transaction Schedules), Schedule H (Financial Information), Schedule R (Retirement Plan Information), and the other financial schedules described in § 2520.103–10. See the instructions for this form.

(2) Separate financial statements (in addition to the information required by paragraph (b)(1) of this section), if such financial statements are prepared in order for the independent qualified public accountant to form the opinion required by section 103(a)(3)(A) of the Act and § 2520.103–1(b)(5). These statements shall include the following:

(i) A statement of assets and liabilities at current value presented in comparative form for the beginning and end of the year. The statement of plan assets and liabilities shall include the assets and liabilities required to be reported on the Form 5500; however, the assets and liabilities may be aggregated into categories in a manner other than that used on Form 5500.

(ii) Separate or combined statements of plan income and expenses and of changes in net assets which include the categories of income, expense, and changes in assets reqired to be reported on the Form 5500; however the income, expense, and changes in net assets may be aggregated into categories in a manner other than that used on Form 5500.

(3) Notes to the financial statements described in paragraph (b)(1) or (2) of this section which contain a description of the accounting principles and practices reflected in the financial statements and, if applicable, variances from generally accepted accounting principles; a description of the plan, including any significant changes in the plan made during the period and the impact of such changes on benefits; the funding policy (including policy with respect to prior service cost) and any changes in such policy from the prior year, a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; an explanation of the differences, if any, between the information contained in the separate financial statements and the assets, liabilities, income, expenses and changes in the net assets as required to be reported on the Form 5500, and any other matters necessary to fully and fairly present the financial condition of the plan.

(4) In the case of a plan, some or all of the assets of which are held in a pooled separate account maintained by an insurance company, or a common or collective trust maintained by a bank or similar institution, a copy of the annual statement of assets and liabilities of such account or trust for the fiscal year of the account or trust which ends with or within the plan year for which the annual report is made as required to be furnished to the administrator by such account or trust under § 2520.103–5(c). Although the statement of assets and liabilities referred to in § 2520.103–5(c) shall be considered part of the plan's annual report, such statement of assets and liabilities need not be filed with the plan's annual report. See §§ 2520.103–3 and 2520.103–4 for reporting requirements for plans some or all of the assets of which are held in a pooled separate account maintained by an insurance company, or a common or collective trust maintained by a bank or similar institution.

(5) A report of an independent qualified public accountant.

(i) *Technical requirements.* The accountant's report—

(A) Shall be dated;

(B) Shall be signed manually;

(C) Shall indicate the city and state where issued; and

(D) Shall identify without detailed enumeration the financial statements and schedules covered by the report.

(ii) *Representations as to the audit.* The accountant's report—

(A) Shall state whether the audit was made in accordance with generally accepted auditing standards; and

(B) Shall designate any auditing procedures deemed necessary by the accountant under the circumstances of the particular case which have been omitted, and the reasons for their omission. Authority for the omission of certain procedures which independent accountants might ordinarily employ in the course of an audit made for the purpose of expressing the opinions required by paragraph (b)(5)(iii) of this section is contained in §§ 2520.103–8 and 2520.103–12.

(iii) *Opinion to be expressed.* The accountant's report shall state clearly:

(A) The opinion of the accountant in respect of the financial statements and schedules covered by the report and the accounting principles and practices reflected therein; and

(B) The opinion of the accountant as to the consistency of the application of the accounting principles with the application of such principles in the preceding year or as to any changes in such principles which have a material effect on the financial statements.

(iv) *Exceptions.* Any matters to which the accountant takes exception shall be clearly identified, the exception thereto specifically and clearly stated, and, to the extent practicable, the effect of the matters to which the accountant takes exception on the related financial statements given. The matters to which the accountant takes exception shall be further identified as (A) those that are the result of DOL regulations, and (B) all others.

(c) *Contents of the annual report for plans with fewer than 100 participants.* Except as provided in paragraph (d) of this section and in §§ 2520.104–43 and 2520.104a–6, the annual report of an employee benefit plan which covers fewer than 100 participants at the beginning of the plan year shall include a Form 5500 ''Annual Return/Report of Employee Benefit Plan'' and any statements or schedules required to be attached to the form, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule B (Actuarial Information), Schedule D (DFE/Participating Plan Information), Schedule I (Financial Information—Small Plan), and Schedule R (Retirement Plan Information). See the instructions for this form.

(d) *Special rule.* If a plan has between 80 and 120 participants (inclusive) as of the beginning of the plan year, the plan administrator may elect to file the same category of annual report (i.e., the annual report for plans with 100 or more participants under paragraph (b) of this section or the annual report for plans with fewer than 100 participants under paragraph (c) of this section) that was filed for the previous plan year.

(e) *Plans which participate in a master trust.* The plan administrator of a plan which participates in a master trust shall file an annual report on Form 5500 in accordance with the instructions for the form relating to master trusts and master trust investment accounts. For purposes of annual reporting, a master trust is a trust for which a regulated financial institution serves as trustee or custodian (regardless of whether such institution exercises discretionary authority or control respecting the management of assets held in the trust) and in which assets of more than one plan sponsored by a single employer or by a group of employers under common control are held. For purpose of this paragraph, a regulated financial institution is a bank, trust company, or similar financial institution regulated, supervised, and subject to periodic examination by a State or Federal agency. Common control is determined on the basis of all relevant facts and circumstances (whether or not such employers are incorporated).

(f) *Electronic filing.* The Form 5500 ''Annual Return/Report of Employee Benefit Plan'' may be filed electronically or through other media in accordance with the instructions accompanying the form, provided the plan administrator maintains an original copy, with all required signatures, as part of the plan's records.

[43 FR 10140, Mar. 10, 1978, as amended at 45 FR 51446, Aug. 1, 1980; 46 FR 61079, Dec. 15, 1981; 51 FR 41288, Nov. 13, 1986; 54 FR 8627, Mar. 1, 1989; 65 FR 21080, Apr. 19, 2000]

§ 2520.103–2 Contents of the annual report for a group insurance arrangement.

(a) *General.* (1) A trust or other entity described in § 2520.104–43(b) that files an annual report for purposes of § 2520.104–43 shall include in such report the items set forth in paragraph (b) of this section.

(2) [Reserved]

(b) *Contents.* (1) A Form 5500 ''Annual Return/Report of Employee Benefit Plan'' and any statements or schedules required to be attached to the form, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule C (Service Provider Information), Schedule D (DFE/Participating Plan Information), Schedule G (Financial Transaction Schedules), Schedule H (Financial Information), and the other financial schedules described in § 2520.103–10. See the instructions for this form.

(2) Separate financial statements (in addition to the information required by paragraph (b)(1) of this section), if such financial statements are prepared in order for the independent qualified public accountant to form the opinion required by section 103(a)(3)(A) of the Act and § 2520.103–2(b)(5). These financial statements shall include the following:

(i) A statement of all trust assets and liabilities at current value presented in comparative form for the beginning and end of the year. The statement of trust assets and liabilities shall include the assets and liabilities required to be reported on the Form 5500; however, the assets and liabilities may be aggregated into categories in a manner other than that used on Form 5500.

(ii) Separate or combined statements of all trust income and expenses and changes in net assets which includes the categories of income, expense, and changes in assets required to be reported on the Form 5500; however, the income, expense, and changes in assets may be aggregated into categories in a manner other than that used on Form 5500.

(3) Notes to the financial statements described in paragraph (b)(1) or (2) of this section which contain a description of the accounting principles and practices reflected in the financial statements and, if applicable, variances from generally accepted accounting principles; a description of the group insurance arrangement including any significant changes in the group insurance arrangement made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; an explanation of the differences, if any, between the information contained in the separate financial statements and the assets, liabilities, income, expenses and changes in net assets as required to be reported on the Form 5500; and any other matters necessary to fully and fairly present the financial condition of the plan.

(4) In the case of a group insurance arrangement some or all of the assets of which are held in a pooled separate account maintained by an insurance carrier, or in a common or collective trust maintained by a bank, trust company or similar institution, a copy of the annual statement of assets and liabilities of such account or trust for the fiscal year of the account or trust which ends with or within the plan year for which the annual report is made as required to be furnished by such account or trust under § 2520.103–5(c). Although the statement of assets and liabilities referred to in § 2520.103–5(c) shall be considered part of the group insurance arrangement's annual report, such statement of assets and liabilities need not be filed with its annual report. See §§ 2520.103–3 and 2520.103–4 for reporting requirements for plans some or all of the assets of which are held in a pooled separate account maintained by an insurance company, or a common or collective trust maintained by a bank or similar institution, and see § 2520.104–43(b)(2) for when the terms ''group insurance arrangement'' or ''trust or other entity'' shall be, respectively, used in place of the terms ''plan'' and ''plan administrator.''

(5) A report of an independent qualified public accountant.

(i) *Technical requirements*. The accountant's report—

(A) Shall be dated;

(B) Shall be signed manually;

(C) Shall indicate the city and State where issued; and

(D) Shall identify without detailed enumeration the financial statements and schedules covered by the report.

(ii) *Representations as to the audit*. The accountant's report—

(A) Shall state whether the audit was made in accordance with generally accepted auditing standards; and

(B) Shall designate any auditing procedures deemed necessary by the accountant under the circumstances of the particular case, which have been omitted, and the reasons for their omission. Authority for the omission of certain procedures which independent accountants might ordinarily employ in the course of an audit made for the purpose of expressing the opinions required by paragraph (b)(5)(iii) of this section is contained in § 2520.103–8.

(iii) *Opinion to be expressed*. The accountant's report shall state clearly:

(A) The opinion of the accountant in respect of the financial statements and schedules covered by the report and the accounting principles and practices reflected therein; and

(B) The opinion of the accountant as to the consistency of the application of the accounting principles with the application of such priniciples in the preceding year, or as to any changes in such principles which have a material effect on the financial statements.

(iv) *Exceptions*. Any matters to which the accountant takes exception shall be clearly identified, the exception thereto specifically and clearly stated, and, to the extent practicable, the effect of the matters to which the accountant takes exception on the related financial statements given. The matters to which the accountant takes exception shall be further identified as to (A) those that are the result of DOL regulations and (B) all others.

(c) *Electronic filing*. The Form 5500 ''Annual Return/Report of Employee Benefit Plan'' may be filed electronically or through other media in accordance with the instructions accompanying the form, provided the trust or other entity described in § 2520.104–43(b) maintains an original copy, with all required signatures, as part of the trust's or entity's records.

[43 FR 10140, Mar. 10, 1978, as amended at 54 FR 8627, Mar. 1, 1989; 65 FR 21080, Apr. 19, 2000]

§ 2520.103–3 Exemption from certain annual reporting requirements for assets held in a common or collective trust.

(a) *General*. Under the authority of sections 103(b)(3)(G), 103(b)(4), 104(a)(2)(B), 104(a)(3), 110 and 505 of the Act, a plan whose assets are held in whole or in part in a common or collective trust maintained by a bank, trust company, or similar institution which meets the requirements of paragraph (b) of this section shall include as part of the annual report required to be filed under §§ 2520.104a–5 or 2520.104a–6 the information described in paragraph (c) of this section. Such plan is not required to include in its annual report information concerning the individual transactions of the common or collective trust. This exemption has no application to assets not held in such trusts.

(b) *Application*. This provision applies only to a plan some or all of the assets of which are held in a common or collective trust maintained by a bank, trust company, or similar institution regulated and supervised and subject to periodic examination by a State or Federal agency. For purposes of this section,

(1) A common or collective trust is a trust which consists of the assets of two or more participating entities and is maintained for the collective investment and reinvestment of assets contributed thereto, and

(2) Plans maintained by a single employer or by the members of a controlled group of corporations, as defined in section 1563(a) of the Internal Revenue Code of 1954, shall be deemed to be a single participating entity.

(c) *Contents*. (1) A plan which meets the requirements of paragraph (b) of this section, and which invests in a common or collective trust that files a Form 5500 report in accordance with § 2520.103–9, shall include in its annual

report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of and net investment gain or loss relating to the units of participation in the common or collective trust held by the plan; identifying information about the common or collective trust including its name, employer identification number, and any other information required by the instructions to the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan's units of participation in the common or collective trust and transactions involving the acquisition and disposition by the plan of units of participation in the common or collective trust.

(2) A plan which meets the requirements of paragraph (b) of this section, and which invests in a common or collective trust that does not file a Form 5500 report in accordance with § 2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of the plan's allocable portion of the underlying assets and liabilities of the common or collective trust and the net investment gain or loss relating to the units of participation in the common or collective trust held by the plan; identifying information about the common or collective trust including its name, employer identification number, and any other information required by the instructions to the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan's units of participation in the common or collective trust and transactions involving the acquisition and disposition by the plan of units of participation in the common or collective trust.

[43 FR 10140, Mar. 10, 1978, as amended at 65 FR 21081, Apr. 19, 2000]

§ 2520.103–4 Exemption from certain annual reporting requirements for assets held in an insurance company pooled separate account.

(a) *General.* Under the authority of sections 103(b)(3)(G), 103(b)(4), 104(a)(2)(B), 104(a)(3), 110 and 505 of the Act, a plan whose assets are held in whole or in part in a pooled separate account of an insurance carrier which meets the requirements of paragraph (b) of this section shall include as part of the annual report required to be filed under § 2520.104a–5 or § 2520.104a–6 the information described in paragraph (c) of this section. Such plan is not required to include in its annual report information concerning the individual transactions of the pooled separate account. This exemption has no application to assets not held in such a pooled separate account.

(b) *Application.* This provision applies only to a plan some or all of the assets of which are held in a pooled separate account of an insurance carrier regulated and supervised and subject to periodic examination by a State agency. For purposes of this section, (1) a pooled separate account is an account which consists of the assets of two or more participating entities and is maintained for the collective investment and reinvestment of assets contributed thereto, and (2) plans maintained by a single employer or by members of a controlled group of corporations, as defined in section 1563(a) of the Internal Revenue Code of 1954, shall be deemed to be a single participating entity.

(c) *Contents.* (1) A plan which meets the requirements of paragraph (b) of this section, and which invests in a pooled separate account that files a Form 5500 report in accordance with § 2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of, and net investment gain or loss relating to, the units of participation in the pooled separate account held by the plan; identifying information about the pooled separate account including its name, employer identification number, and any other information required by the instructions to

the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan's units of participation in the pooled separate accounts and transactions involving the acquisition and disposition by the plan of units of participation in the pooled separate account.

(2) A plan which meets the requirements of paragraph (b) of this section, and which invests in a pooled separate account that does not file a Form 5500 report in accordance with § 2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of the plan's allocable portion of the underlying assets and liabilities of the pooled separate account and the net investment gain or loss relating to the units of participation in the pooled separate account held by the plan; identifying information about the pooled separate account including its name, employer identification number, and any other information required by the instructions to the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan's units of participation in the pooled separate account and transactions involving the acquisition and disposition by the plan of units of participation in the pooled separate account.

[43 FR 10140, Mar. 10, 1978, as amended at 65 FR 21081, Apr. 19, 2000]

§ 2520.103–5 Transmittal and certification of information to plan administrator for annual reporting purposes.

(a) *General.* In accordance with section 103(a)(2) of the Act, an insurance carrier or other organization which provides benefits under the plan or holds plan assets, a bank or similar institution which holds plan assets, or a plan sponsor shall transmit and certifty such information as needed by the administrator to file the annual report under section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6:

(1) Within 9 months after the close of the plan year which begins in 1975 or September 30, 1976, whichever is later, and

(2) Within 120 days after the close of any plan year which begins after December 31, 1975.

(b) *Application.* This requirement applies with respect to—

(1) An insurance carrier or other organization which:

(i) Provides from its general asset account funds for the payment of benefits under a plan, or

(ii) Holds assets of a plan in a separate account;

(2) A bank, trust company, or similar institution which holds assets of a plan in a common or collective trust, separate trust, or custodial account; and

(3) A plan sponsor as defined in section 3(16)(B) of the Act.

(c) *Contents.* The information required to be provided to the administrator shall include—

(1) In the case of an insurance carrier or other organization which:

(i) Provides funds from its general asset account for the payment of benefits under a plan, upon request of the plan administrator, such information as is contained within the ordinary business records of the insurance carrier or other organization and is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6;

(ii) Holds assets of a plan in a pooled separate account and files a Form 5500 report pursuant to § 2520.103–9 for the participating plan's plan year—

(A) A copy of the annual statement of assets and liabilities of the separate account for the fiscal year of such account ending with or within the plan year for which the participating plan's annual report is made,

(B) A statement of the value of the plan's units of participation in the separate account,

(C) The Employer Identification Number (EIN) of the separate account, entity number required for purposes of completing the Form 5500 and any other identifying number assigned by the insurance carrier to the separate account,

(D) A statement that a filing pursuant to § 2520.103–9(c) will be made for the separate account (for its fiscal year ending with or within the participating plan's plan year) on or before the filing due date for such account in accordance with the Form 5500 instructions, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the insurance carrier and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6;

(iii) Holds assets of a plan in a pooled separate account and does not file a Form 5500 report pursuant to § 2520.103–9 for the participating plan's plan year—

(A) A copy of the annual statement of assets and liabilities of the separate account for the fiscal year of such account that ends with or within the plan year for which the participating plan's annual report is made,

(B) A statement of the value of the plan's units of participation in the separate account,

(C) The EIN of the separate account and any other identifying number assigned by the insurance carrier to the separate account,

(D) A statement that a filing pursuant to § 2520.103–9(c) will not be made for the separate account for its fiscal year ending with or within the participating plan's plan year, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the insurance carrier and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6.

(iv) Holds assets of a plan in a separate account which is not exempted from certain reporting requirements under § 2520.103–4, a listing of all transactions of the separate account and, upon request of the plan administrator, such information as is contained within the ordinary business records of the insurance carrier and is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6.

(2) In the case of a bank, trust company, or similar institution holding assets of a plan—

(i) In a common or collective trust that files a Form 5500 report pursuant to § 2520.103–9 for the participating plan's plan year—

(A) A copy of the annual statement of assets and liabilities of the common or collective trust for the fiscal year of such trust ending with or within the plan year for which the participating plan's annual report is made,

(B) A statement of the value of the plan's units of participation in the common or collective trust,

(C) The EIN of the common or collective trust, entity number assigned for purposes of completing the Form 5500 and any other identifying number assigned by the bank, trust company, or similar institution,

(D) A statement that a filing pursuant to § 2520.103–9(c) will be made for the common or collective trust (for its fiscal year ending with or within the participating plan's plan year) on or before the filing due date for such trust in accordance with the Form 5500 instructions, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the bank, trust company or similar institution and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and §§ 2520.104a–5 or 2520.104a–6.

(ii) In a common or collective trust that does not file a Form 5500 report pursuant to § 2520.103–9 for the participating plan's plan year—

(A) A copy of the annual statement of assets and liabilities of the common or collective trust for the fiscal year of such account that ends with or within the plan year for which the participating plan's annual report is made,

(B) A statement of the value of the plan's units of participation in the common or collective trust,

(C) The EIN of the common or collective trust and any other identifying number assigned by the bank, trust company or similar institution,

(D) A statement that a filing pursuant to § 2520.103–9(c) will not be made for the common or collective trust for

its fiscal year ending with or within the participating plan's plan year, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the bank, trust company or similar institution and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and §§ 2520.104a–5 or 2520.104a–6.

(iii) In a trust which is not exempted from certain reporting requirements under § 2520.103–3, a listing of all transactions of the separate trust and, upon request of the plan administrator, such information as is contained within the ordinary business records of the bank, trust company, or similar institution and is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5.

(iv) In a custodial account, upon request of the plan administrator, such information as is contained within the ordinary business records of the bank, trust company, or similar institution and is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6.

(3) In the case of a plan sponsor, a listing of all transactions directly or indirectly involving plan assets engaged in by the plan sponsor and such information as is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6.

(d) *Certification.* (1) An insurance carrier or other organization, a bank, trust company, or similar institution, or plan sponsor, as described in paragraph (b) of this section, shall certify to the accuracy and completeness of the information described in paragraph (c) of this section by a written declaration which is signed by a person authorized to represent the insurance carrier, bank, or plan sponsor. Such certification will serve as a written assurance of the truth of the facts stated therein.

(2) *Example of Certification.* The XYZ Bank (Insurance Carrier) hereby certifies that the foregoing statement furnished pursuant to 29 CFR 2520.103–5(c) is complete and accurate.

[43 FR 10140, Mar. 10, 1978, as amended at 65 FR 21082, Apr. 19, 2000]

§ 2520.103–6 Definition of reportable transaction for Annual Return/Report.

(a) *General.* For purposes of preparing the schedule of reportable transactions described in § 2520.103–10(b)(6), and subject to the exceptions provided in §§ 2520.103–3, 2520.103–4 and 2520.103–12, with respect to individual transactions by a common or collective trust, pooled separate account, or a 103–12 investment entity, a reportable transaction includes any transaction or series of transactions described in paragraph (c) of this section.

(b) *Definitions.* (1)(i) Except as provided in paragraphs (c)(2) and (d)(1)(vi) of this section (relating to assets acquired or disposed of during the plan year), ''current value'' shall mean the current value, as defined in section 3(26) of the Act, of plan assets as of the beginning of the plan year, or the end of the previous plan year.

(ii) Except as provided in paragraphs (c)(2) and (d)(1)(vi) of this section (relating to assets acquired or disposed of during the plan year), with respect to schedules of reportable transactions for the initial plan year of a plan, ''current value'' shall mean the current value, as defined in section 3(26) of the Act, of plan assets at the end of a plan's initial plan year.

(2)(i) A ''transaction with respect to securities'' is any purchase, sale, or exchange of securities. A transaction with respect to securities for purposes of this section occurs on either the trade date or settlement date of a purchase, sale, or exchange of securities; either the trade date or settlement date must be used consistently during the plan year for the purposes of this section. For the purposes of this section, except as provided in paragraph (b)(2)(ii) of this section, ''securities'' includes a unit of participation in a common or collective trust or a pooled separate account.

(ii) Solely for purposes of paragraph (c)(1)(iv) of this section, the term ''securities'', as it applies to any transaction involving a bank or insurance

company regulated by a Federal or State agency, an investment company registered under the Investment Company Act of 1940, or a broker-dealer registered under the Securities Exchange Act of 1934, shall not include:

(A) Debt obligations of the United States or any United States agency with a maturity of not more than one year;

(B) Debt obligations of the United States or any United States agency with a maturity of more than one year if purchased or sold under a repurchase agreement having a term of less than 91 days;

(C) Interests issued by a company registered under the Investment Company Act of 1940;

(D) Bank certificates of deposit with a maturity of not more than one year;

(E) Commercial paper with a maturity of not more than nine months if it is ranked in the highest rating category for commercial paper by at least two nationally recognized statistical rating services and is issued by a company required to file reports under section 13 of the Securities Exchange Act of 1934;

(F) Participations in a bank common or collective trust;

(G) Participations in an insurance company pooled separate account;

(3)(i) Except as provided by paragraph (b)(3)(ii) of this section, a transaction is ''with or in conjunction with a person'' for purposes of this section if that person benefits from, executes, facilitates, participates, promotes, or solicits a transaction or part of a transaction involving plan assets.

(ii) Solely for the purposes of paragraph (c)(1)(iv) of this section, a transaction shall not be considered ''with or in conjunction with a person'' if:

(A) That person is a broker-dealer registered under the Securities Exchange Act of 1934;

(B) The transaction involves the purchase or sale of securities listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 or quoted on NASDAQ; and

(C) The broker-dealer does not purchase or sell securities involved in the transaction for its own account or the account of an affiliated person.

(c) *Application*. (1) Except as provided in paragraph (c)(4) of this section, this provision applies to—

(i) A transaction within the plan year, with respect to any plan asset, involving an amount in excess of 3 percent of the current value of plan assets;

(ii) Any series of transactions (other than transactions with respect to securities) within the plan year with or in conjunction with the same person which, when aggregated, regardless of the category of asset and the gain or loss on any transaction, involves an amount in excess of 3 percent of the current value of plan assets;

(iii) Any transaction within the plan year involving securities of the same issue if within the plan year any series of transactions with respect to such securities, when aggregated, involves an amount in excess of 3 percent of the current value of plan assets; and

(iv) Any transaction within the plan year with respect to securities with or in conjunction with a person if any prior or subsequent single transaction within the plan year with such person with respect to securities exceeds 3 percent of the current value of plan assets.

(2) For purposes of determining whether any 3 percent transactions occur, the ''current value'' of an asset acquired or disposed of during the plan year is the current value, as defined in section 3(26) of the Act, at the time of acquisition or disposition of such asset.

(3) Plans whose assets are held in whole or in part in a common or collective trust or a pooled separate account, as provided in §§ 2520.103–3 and 2520.103–4, and which satisfy the requirements of those sections, are not required to prepare schedules of reportable transactions with respect to the individual transactions of the common or collective trust or pooled separate account.

(4) For plan years beginning on or after January 1, 1988, 5 percent shall be substituted for 3 percent in paragraphs (c)(1) and (2) of this section for purposes of determining whether a transaction or series of transactions constitutes a reportable transaction under this section.

(d) *Contents*. (1) The schedule of transactions shall include the following information as to each transaction or series of transactions:

(i) The name of each party, except that in the case of a transaction or series of transactions involving a purchase or sale of a security on the market, the schedule need not include the person from whom it was purchased or to whom it was sold. A purchase or sale on the market is a purchase or sale of a security through a registered broker-dealer acting as a broker under the Securities Exchange Act of 1934;

(ii) A brief description of each asset;

(iii) The purchase or selling price in the case of a purchase or sale, the rental in the case of a lease, and the amount of principal, interest rate, payment schedule (e.g., fully amortized, partly amortized with balloon) and maturity date in the case of a loan;

(iv) Expenses incurred, including, but not limited to, any fees or commissions;

(v) The cost of any asset;

(vi) The current value of any asset acquired or disposed of at the time of acquisition or disposition; and

(vii) The net gain or loss.

(2) The schedule of transactions with respect to a series of transactions described in paragraph (c)(1)(iii) may include the following information for each issue in lieu of the information prescribed in paragraphs (d)(1)(i) through (vii):

(i) The total number of purchases of such securities made by the plan within the plan year;

(ii) The total number of sales of such securities made by the plan within the plan year;

(iii) The total dollar value of such purchases;

(iv) The total dollar value of such sales;

(v) The net gain or loss as a result of these transactions.

(e) *Examples*. These examples are effective for reporting for plan years beginning on or after January 1, 1988.

(1) At the beginning of the plan year, XYZ plan has 10 percent of the current value of its plan assets invested in ABC common stock. Halfway through the plan year, XYZ purchases ABC common stock in a single transaction in an amount equal to 6 percent of the current value of plan assets. At about this time, XYZ plan also purchases a commercial development property in an amount equal to 8 percent of the current value of plan assets. Under paragraph (c)(1)(i) of this section, the 6 percent stock transaction is a reportable transaction for the plan year because it exceeds 5 percent of the current value of plan assets. The 8 percent land transaction is also reportable under paragraph (c)(1)(i) of this section because it exceeds 5 percent of the current value of plan assets.

(2) During the plan year, AAA plan purchases a commercial lot from ZZZ corporation at a cost equal to 2 percent of the current value of the plan assets. Two months later, AAA plan loans ZZZ corporation an amount of money equal to 3.5 percent of the current value of plan assets. Under the provisions of paragraph (c)(1)(ii) of this section, the plan has engaged in a reportable series of transactions with or in conjunction with the same person, ZZZ corporation, which when aggregated involves 5.5 percent of plan assets.

(3) During the plan year NMN plan sells to OPO corporation a commercial property that represents 3.5 percent of the current value of plan assets. OPO simultaneously executes a note and mortgage on the purchased property to NMN which represents 3 percent of the current value of plan assets. Under the provisions of paragraph (c)(1)(ii) of this section, NMN has engaged in a reportable series of transactions with or in conjunction with the same person, OPO corporation, consisting of a simultaneous sale of property and a loan, which, when aggregated, involves 6.5 percent of the current value of plan assets.

(4) At the beginning of the plan year, ABC plan has 10 percent of the current value of plan assets invested equally in a combination of XYZ Corporation common stock and XYZ preferred stock. One month into the plan year, ABC sells some of its XYZ common stock in an amount equal to 2 percent of the current value of plan assets.

(i) Six weeks later the plan sells XYZ preferred stock in an amount equal to 4 percent of the current value of plan assets. A reportable series of transactions has not occurred because only transactions involving securities of the same issue are to be aggregated under paragraph (c)(1)(iii) of this section.

(ii) Two weeks later when the ABC plan purchases XYZ common stock in an amount equal to 3.5 percent of the current value of plan assets, a reportable series of transactions under paragraph (c)(1)(iii) of this section has occurred. The sale of XYZ common stock worth 2 percent of plan assets and the purchase of XYZ common stock worth 3.5 percent of plan assets aggregate to exceed 5 percent of the total value of plan assets.

(5) At the beginning of the plan year, Plan X purchases through broker-dealer Y common stock of Able Industries in an amount equal to 6 percent of plan assets. The common stock of Able Industries is not listed on any national securities exchange or quoted on NASDAQ. This purchase is a reportable transaction under paragraph (c)(1)(i) of this section. Three months later, Plan X purchases short term debt obligations of Charley Company through broker-dealer Y in the amount of 0.2 percent of plan assets. This purchase is also a reportable transaction under the provisions of paragraph (c)(1)(iv) of this section.

(6) At the beginning of the plan year, Plan X purchases from Bank B certificates of deposit having a 180 day maturity in an amount equal to 6 percent of plan assets. Bank B is a national bank regulated by the Comptroller of the Currency. This purchase is a reportable transaction under paragraph (c)(1)(i) of this section. Three months later, Plan X purchases through Bank B 91-day Treasury bills in the amount of 0.2 percent of plan assets. This purchase is not a reportable transaction under paragraph (c)(1)(iv) of this section because the purchase of the Treasury bills as well as the purchase of the certificates of deposit are not considered to involve a security under the definition of ''securities'' in paragraph (b)(2)(ii) of this section.

(7) At the beginning of the plan year, Plan X purchases through broker-dealer Y common stock of Able Industries, a New York Stock Exchange listed security, in an amount equal to 6 percent of plan assets. This purchase is a reportable transaction under paragraph (c)(1)(i) of this section. Three months later, Plan X purchases through broker-dealer Y, acting as agent, common stock of Baker Corporation, also a New York Stock Exchange listed security, in an amount equal to 0.2 percent of plan assets. This latter purchase is not a reportable transaction under paragraph (c)(1)(iv) of this section because it is not a transaction ''with or in conjunction with a person'' pursuant to paragraph (b)(3)(ii) of this section.

(f) *Special rule for certain participant-directed transactions.* Participant or beneficiary directed transactions under an individual account plan shall not be taken into account under paragraph (c)(1) of this section for purposes of preparing the schedule of reportable transactions described in this section. For purposes of this section only, a transaction will be considered directed by a participant or beneficiary if it has been authorized by such participant or beneficiary.

[43 FR 10140, Mar. 10, 1978; 43 FR 14009, Apr. 4, 1978, as amended at 54 FR 8628, Mar. 1, 1989; 61 FR 33849, July 1, 1996; 65 FR 21082, Apr. 19, 2000]

§ 2520.103–8 Limitation on scope of accountant's examination.

(a) *General.* Under the authority of section 103(a)(3)(C) of the Act, the examination and report of an independent qualified public accountant need not extend to any statement or information prepared and certified by a bank or similar institution or insurance carrier. A plan, trust or other entity which meets the requirements of paragraph (b) of this section is not required to have covered by the accountant's examination or report any of the information described in paragraph (c) of this section.

(b) *Application.* This section applies to any plan, trust or other entity some or all of the assets of which are held by a bank or similar institution or insurance carrier which is regulated and supervised and subject to periodic examination by a State or Federal agency.

(c) *Excluded information.* Any statements or information certified to by a bank or similar institution or insurance carrier described in paragraph (b) of this section, provided that the statements or information regarding assets so held are prepared and certified to by the bank or insurance carrier in accordance with § 2520.103–5.

§ 2520.103–9 Direct filing for bank or insurance carrier trusts and accounts.

(a) *General.* Under the authority of sections 103(b)(4), 104(a)(3), 110 and 505 of the Act, an employee benefit plan, some or all of the assets of which are held in a common or collective trust or a pooled separate account described in section 103(b)(3)(G) of the Act and §§ 2520.103–3 and 2520.103–4, is relieved from including in its annual report information about the current value of the plan's allocable portion of assets and liabilities of the common or collective trust or pooled separate account and information concerning the individual transactions of the common or collective trust or pooled separate account, provided that the plan meets the requirements of paragraph (b) of this section, and, provided further, that the bank or insurance carrier which holds the plan's assets meets the requirements of paragraph (c) of this section.

(b) *Application.* A plan whose assets are held in a common or collective trust or a pooled separate account described in section 103(b)(3)(G) of the Act and §§ 2520.103–3 and 2520.103–4, provided the plan administrator, on or before the end of the plan year, provides the bank or insurance carrier which maintains the common or collective trust or pooled separate account with the plan number, and name and Employer Identification Number of the plan sponsor as will be reported on the plan's annual report.

(c) *Separate filing by common or collective trusts and pooled separate accounts.* The bank or insurance carrier which maintains the common or collective trust or pooled separate account in which assets of the plan are held shall file, in accordance with the instructions for the form, a completed Form 5500 ''Annual Return/Report of Employee Benefit Plan'' and any statements or schedules required to be attached to the form for the common or collective trust or pooled separate account, including Schedule D (DFE/Participating Plan Information) and Schedule H (Financial Information). See the instructions for this form. The information reported shall be for the fiscal year of such trust or account ending with or within the plan year for which the annual report of the plan is made.

(d) *Method of filing.* The Form 5500 ''Annual Return/Report of Employee Benefit Plan'' may be filed electronically or through other media in accordance with the instructions accompanying the form, provided the bank or insurance company which maintains the common or collective trust or pooled separate account maintains an original copy, with all required signatures, as part of its records.

[65 FR 21082, Apr. 19, 2000]

§ 2520.103–10 Annual report financial schedules.

(a) *General.* The administrator of a plan filing an annual report pursuant to § 2520.103–1(a)(2) or the report for a group insurance arrangement pursuant to § 2520.103–2 shall, as provided in the instructions to the Form 5500 ''Annual Return/Report of Employee Benefit Plan,'' include as part of the annual report the separate financial schedules described in paragraph (b) of this section.

(b) *Schedules.* (1) *Assets held for investment.* (i) A schedule of all assets held for investment purposes at the end of the plan year (see § 2520.103–11) with assets aggregated and identified by:

(A) Identity of issue, borrower, lessor or similar party to the transaction (including a notation as to whether such party is known to be a party in interest);

(B) Description of investment including maturity date, rate of interest, collateral, par, or maturity value;

(C) Cost; and

(D) Current value, and, in the case of a loan, the payment schedule.

(ii) Except as provided in the Form 5500 and the instructions thereto, in the case of assets or investment interests of two or more plans maintained in one trust, all entries on the schedule of assets held for investment purposes that relate to the trust shall be completed by including the plan's allocable portion of the trust.

(2) *Assets acquired and disposed within the plan year.* (i) A schedule of all assets acquired and disposed of within the plan year (see § 2520.103–11) with assets aggregated and identified by:

(A) Identity of issue, borrower, issuer or similar party;

(B) Descriptions of investment including maturity date, rate of interest, collateral, par, or maturity value;

(C) Cost of acquisitions; and

(D) Proceeds of dispositions.

(ii) Except as provided in the Form 5500 and the instructions thereto, in the case of assets or investment interests of two or more plans maintained in one trust, all entries on the schedule of assets held for investment purposes that relate to the trust shall be completed by including the plan's allocable portion of the trust.

(3) *Party in interest transactions.* A schedule of each transaction involving a person known to be a party in interest except do not include:

(i) A transaction to which a statutory exemption under part 4 of title I applies;

(ii) A transaction to which an administrative exemption under section 408(a) of the Act applies; or

(iii) A transaction to which the exemptions of section 4975(c) or 4975(d) of the Internal Revenue Code (Title 26 of the United States Code) applies.

(4) *Obligations in default.* A schedule of all loans or fixed income obligations which were in default as of the end of the plan year or were classified during the year as uncollectible.

(5) *Leases in default.* A schedule of all leases which were in default or were classified during the year as uncollectible.

(6) *Reportable transactions.* A schedule of all reportable transactions as defined in § 2520.103–6.

(c) *Format requirements for certain schedules.* See the instructions to the Form 5500 ''Annual Return/Report of Employee Benefit Plan'' as to the format requirement for the schedules referred to in paragraphs (b)(1), (b)(2) or (b)(6) of this section.

[65 FR 21083, Apr. 19, 2000]

§ 2520.103–11 Assets held for investment purposes.

(a) *General.* For purposes of preparing the schedule of assets held for investment purposes described in § 2520.103–10(b)(1) and (2), assets held for investment purposes include those assets described in paragraph (b) of this section.

(b) *Definitions.* (1) Assets held for investment purposes shall include:

(i) Any investment asset held by the plan on the last day of the plan year; and

(ii) Any investment asset which was purchased at any time during the plan year and was sold at any time before the last day of the plan year, except as provided by paragraphs (b)(2) and (b)(3) of this section.

(2) Assets held for investment purposes shall not include any investment which was not held by the plan on the last day of the plan year for which the annual report is filed if that investment falls within any of the following categories:

(i) Debt obligations of the United States or any agency of the United States;

(ii) Interests issued by a company registered under the Investment Company Act of 1940;

(iii) Bank certificates of deposit with a maturity of not more than one year;

(iv) Commerical paper with a maturity of not more than nine months if it is ranked in the highest rating category by at least two nationally recognized statistical rating services and is issued by a company required to file reports with the Securities and Exchange Commission under section 13 of the Securities Exchange Act of 1934;

(v) Participations in a bank common or collective trust;

(vi) Participations in an insurance company pooled separate account;

(vii) Securities purchased from a person registered as a broker-dealer under the Securities Exchange Act of 1934 and listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 or quoted on NASDAQ;

(3) Assets held for investment purposes shall not include any investment which was not held by the plan on the last day of the plan year for which the annual report is filed if that investment is reported on the annual report of that same plan in any of the following:

(i) The schedule of each transaction involving a person known to be a party in interest required by section 103(b)(3)(D) of the Act and § 2520.103–10(b)(3);

(ii) The schedule of loans or fixed income obligations in default required by section 103(b)(3)(E) of the Act and § 2520.103–10(b)(4);

(iii) The schedule of leases in default or classified as uncollectible required by section 103(b)(3)(F) of the Act and § 2520.103–10(b)(5); or

(iv) The schedule of reportable transactions required by section 103(b)(3)(H) of the Act and § 2520.103–10(b)(6).

(c) *Examples.* (1) On February 1, 1977, plan N purchases an interest in registered investment company F (fund F). Fund F is not a party in interest with respect to plan N. On November 1, 1977, plan N sells this interest in fund F and purchases 1,000 shares of stock S, which the plan holds for the rest of the plan year. Plan N must include in its schedule of assets held for investment purposes the 1,000 shares of stock S under paragraph (b)(1) of this section, but need not include the interest in fund F because of paragraph (b)(2)(ii) of this section.

(2) On February 1, 1977, plan N purchases a parcel of real estate from Mr. M, who is not a party in interest with respect to plan N. On November 1, 1977, plan N sells the parcel of real estate for cash to Mr. X, who is not a party in interest with respect to plan N. Plan N uses the cash from this transaction to purchase a 1-year certificate of deposit in bank B, which it holds until maturity in 1978. Plan N must include in its schedule of assets held for investment purposes the 1-year certificate of deposit in bank B under paragraph (b)(1)(i) of this section, and must also include the parcel of real estate under paragraph (b)(1)(ii) of this section.

(d) *Special rule for certain participant-directed transactions.* Cost information may be omitted from the schedule of assets held for investment purposes for assets described in paragraphs (b)(1)(i) and (b)(1)(ii) of this section only with respect to participant or beneficiary directed transactions under an individual account plan. For purposes of this section only, a transaction will be considered directed by a participant or beneficiary if it has been authorized by such participant or beneficiary.

[43 FR 10140, Mar. 10, 1978, as amended at 65 FR 21083, Apr. 19, 2000]

§ 2520.103–12 Limited exemption and alternative method of compliance for annual reporting of investments in certain entities.

(a) This section prescribes an exemption from and alternative method of compliance with the annual reporting requirements of part 1 of title I of ERISA for employee benefit plans whose assets are invested in certain entities described in paragraph (c). A plan utilizing this method of reporting shall include as part of its annual report the current value of its investment or units of participation in the entity in the manner prescribed by the Return/Report Form and the instructions thereto. The plan is not required to include in its annual report any information regarding the underlying assets or individual transactions of the entity, provided the information described in paragraph (b) regarding the entity is reported directly to the Department on behalf of the plan administrator on or before the filing due date for the entity in accordance with the instructions to the Form 5500 Annual Return/Report. The information described in paragraph (b), however, shall be considered as part of the annual report for purposes of the requirements of section 104(a)(1) of the Act and §§ 2520.104a–5 and 2520.104a–6.

(b) The following information must be filed regarding the entity described in paragraph (c) of this section:

(1) A Form 5500 ''Annual Return/Report of Employee Benefit Plan'' and any statements or schedules required to be attached to the form for such entity, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule C (Service Provider Information), Schedule D (DFE/Participating Plan Information), Schedule G (Financial Transaction Schedules), Schedule H (Financial Information), and the schedules described in § 2520.103–10(b)(1) and (b)(2). See the instructions for this form. The information reported shall be for the fiscal year of such entity ending with or within the plan year for which the annual report of the plan is made.

(2) A report of an independent qualified public accountant regarding the financial statements and schedules described in paragraph (b)(1) of this section which meets the requirements of § 2520.103–1(b)(5).

(c) This method of reporting is available to any employee benefit plan which has invested in an entity the assets of which are deemed to include plan assets under § 2510.3–101, provided the entity holds the assets of two or more plans which are not members of a ''related group'' of employee benefit plans as that term is defined in paragraph (e) of this section. The method of reporting is not available for investments in an insurance company pooled separate account or a common or collective trust maintained by a bank, trust company, or similar institution.

(d) The examination and report of an independent qualified public accountant required by § 2520.103–1 for a plan utilizing the method of reporting described in this section need not extend to any information concerning an entity which is reported directly to the Department under paragraph (b) of this section.

(e) A ''related group'' of employee benefit plans consists of every group of two or more employee benefit plans—

(1) Each of which receives 10 percent or more of its aggregate contributions from the same employer or from members of the same controlled group of corporations (as determined under section 1563(a) of the Internal Revenue Code, without regard to section 1563(a)(4) thereof); or

(2) Each of which is either maintained by, or maintained pursuant to a collective bargaining agreement negotiated by, the same employee organization or affiliated employee organizations. For purposes of this paragraph, an ''affiliate'' of an employee organization means any person controlling, controlled by, or under common control with such organization, and includes any organization chartered by the same parent body, or governed by the same constitution and bylaws, or having the relation of parent and subordinate.

(f) *Method of filing.* The Form 5500 ''Annual Return/Report of Employee Benefit Plan'' may be filed electronically or through other media in accordance with the instructions accompanying the form provided the entity described in paragraph (c) of this section maintains an original copy, with all required signatures, as part of its records.

[51 FR 41287, Nov. 13, 1986, as amended at 65 FR 21083, Apr. 19, 2000]

Subpart D—Provisions Applicable to Both Reporting and Disclosure Requirements

(The information collection requirements contained in subpart D were approved by the Office of Management and Budget under control number 1210–0016)

§ 2520.104–1 General.

The administrator of an employee benefit plan covered by part 1 of title I of the Act must file reports and additional information with the Secretary of Labor, and disclose reports, statements, and documents to plan participants and to beneficiaries receiving benefits from the plan. The regulations contained in this subpart are applicable to both the reporting and disclosure requirements of part 1 of title I of the Act. Regulations concerning only a plan administrator's duty of reporting to the Secretary of Labor are set forth in subpart E of this part, and those applicable only to the duty of disclosure to participants and beneficiaries are set forth in subpart F of this part.

[41 FR 16962, Apr. 23, 1976]

§ 2520.104–2—2520.104–3 [Reserved]

§ 2520.104–4 Alternative method of compliance for certain successor pension plans.

(a) *General.* Under the authority of section 110 of the Act, this section sets forth an alternative method of compliance for certain successor pension plans in which some participants and beneficiaries not only have their rights set out in the plan, but also retain eligibility for certain benefits under the terms of a former plan which has been merged into the successor. This section is applicable only to plan mergers which occur after the issuance by the successor plan of the initial summary

plan description under the Act. Under the alternative method, the plan administrator of the successor plan is not required to describe relevant provisions of merged plans in summary plan descriptions of the successor plan furnished after the merger to that class of participants and beneficiaries still affected by the terms of the merged plans.

(b) *Scope and application.* This alternative method of compliance is available only if:

(1) The plan administrator of the successor plan furnishes to the participants covered under the predecessor plan and beneficiaries receiving pension benefits under the merged plan within 90 days after the effective date of the merger:

(i) A copy of the most recent summary plan description of the successor plan;

(ii) A copy of any summaries of material modifications to the successor plan not incorporated in the most recent summary plan description; and

(iii) A separate statement containing a brief description of the merger, a description of the provisions of, and benefits provided by, the merged and successor plans which are applicable to the participants and beneficiaries of the merged plan; and a notice that copies of the merged and successor plan documents, as well as the plan merger documents (including the portions of any corporate merger documents which describe or control the plan merger), are available for inspection and that copies may be obtained upon written request for a duplication charge (pursuant to § 2520.104b–30); and

(2) After the merger, the plan administrator, in all subsequent summary plan descriptions furnished pursuant to § 2520.104b–2(a)—

(i) Clearly and conspicuously identifies the class of participants and beneficiaries affected by the provisions of the merged plan, and

(ii) States that the documents described in paragraph (b)(1) of this section are available for inspection and that copies may be obtained upon written request for a duplication charge (pursuant to § 2520.104b–30).

[42 FR 37182, July 19, 1977, as amended at 67 FR 776, Jan. 7, 2002]

§ 2520.104–5—2520.104–6 [Reserved]

§ 2520.104–20 Limited exemption for certain small welfare plans.

(a) *Scope.* Under the authority of section 104(a)(3) of the Act, the administrator of any employee welfare benefit plan which covers fewer than 100 participants at the beginning of the plan year and which meets the requirements of paragraph (b) of this section is exempted from certain reporting and disclosure provisions of the Act. Specifically, the administrator of such plan is not required to file with the Secretary an annual or terminal report. In addition, the administrator of a plan exempted under this section—

(1) Is not required to furnish participants covered under the plan and beneficiaries receiving benefits under the plan with statements of the plan's assets and liabilities and receipts and disbursements and a summary of the annual report required by section 104(b)(3) of the Act;

(2) Is not required to furnish upon written request of any participant or beneficiary a copy of the annual report and any terminal report, as required by section 104(b)(4) of the Act;

(3) Is not required to make copies of the annual report available for examination by any participant or beneficiary in the principal office of the administrator and such other places as may be necessary, as required by section 104(b)(2) of the Act.

(b) *Application.* This exemption applies only to welfare benefit plans—

(1) Which have fewer than 100 participants at the beginning of the plan year;

(2)(i) For which benefits are paid as needed solely from the general assets of the employer or employee organization maintaining the plan, or

(ii) The benefits of which are provided exclusively through insurance contracts or policies issued by an insurance company or similar organization which is qualified to do business in any State or through a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e–9(d), the premiums for which are paid directly by the employer or employee organization from its general assets or partly from its general assets

and partly from contributions by its employees or members, *Provided*, That contributions by participants are forwarded by the employer or employee organization within three months of receipt, or

(iii) Both; and

(3) For which, in the case of an insured plan—

(i) Refunds, to which contributing participants are entitled, are returned to them within three months of receipt by the employer or employee organization, and

(ii) Contributing participants are informed upon entry into the plan of the provisions of the plan concerning the allocation of refunds.

(c) *Limitations*. This exemption does not exempt the administrator of an employee benefit plan from any other requirement of title I of the Act, including the provisions which require that plan administrators furnish copies of the summary plan description to participants and beneficiaries (section 104(b)(1)) and furnish certain documents to the Secretary of Labor upon request (section 104(a)(6)), and which authorize the Secretary of Labor to collect information and data from employee benefit plans for research and analysis (section 513).

(d) *Examples*. (1) A welfare plan has 75 participants at the beginning of the plan year and 105 participants at the end of the plan year. Plan benefits are fully insured and premiums are paid directly to the insurance company by the employer pursuant to an insurance contract purchased with premium payments derived half from the general assets of the employer and half from employee contributions (which the employer forwards within three months of receipt). Refunds to the plan are paid to participating employees within three months of receipt as provided in the plan and as described to each participant upon entering the plan. The plan appoints the employer as its plan administrator. The employer, as plan administrator, provides summary plan descriptions to participants and beneficiaries. He also makes copies of certain plan documents available at the plan's principal office and such other places as necessary to give participants reasonable access to them. The exemption provided by § 2520.104–20 applies even though the plan has more than 100 participants by the end of the plan year, because it had fewer than 100 participants at the beginning of the plan year and otherwise satisfied the conditions of the exemption.

(2) A welfare plan is established and maintained in the same way as the plan described in example (1), except that a trade association which sponsors the plan is the holder of the insurance contract. Since the plan still sends the premium payments directly to the insurance company, the exemption applies, as in example (1).

[43 FR 10148, Mar. 10, 1978, as amended at 46 FR 5884, Jan. 21, 1981; 67 FR 776, Jan. 7, 2002]

§ 2520.104–21 Limited exemption for certain group insurance arrangements.

(a) *Scope*. Under the authority of section 104(a)(3) of the Act, the administrator of any employee welfare benefit plan which covers fewer than 100 participants at the beginning of the plan year and which meets the requirements of paragraph (b) of this section is exempted from certain reporting and disclosure provisions of the Act. Specifically, the administrator of such plan is not required to file with the Secretary a terminal report or furnish upon written request of any participant or beneficiary a copy of any terminal report as required by section 104(b)(4) of the Act.

(b) *Application*. This exemption applies only to welfare plans, each of which has fewer than 100 participants at the beginning of the plan year and which are part of a group insurance arrangement if such arrangement:

(1) Provides benefits to the employees of two or more unaffiliated employers, but not in connection with a multiemployer plan as defined in section 3(37) of the Act and any regulations prescribed under the Act concerning section 3(37);

(2) Fully insures one or more welfare plans of each participating employer through insurance contracts purchased solely by the employers or purchased partly by the employers and partly by their participating employees, with all benefit payments made by the insurance company: *Provided*, That—

(i) Contributions by participating employees are forwarded by the employers within three months of receipt,

(ii) Refunds, to which contributing participants are entitled, are returned to them within three months of receipt, and

(iii) Contributing participants are informed upon entry into the plan of the provisions of the plan concerning the allocation of refunds; and

(3) Uses a trust (or other entity such as a trade association) as the holder of the insurance contracts and uses a trust as the conduit for payment of premiums to the insurance company.

(c) *Limitations.* This exemption does not exempt the administrator of an employee benefit plan from any other requirement of title I of the Act, including the provisions which require that plan administrators furnish copies of the summary plan description to participants and beneficiaries (section 104(b)(1)), file an annual report with the Secretary of Labor (section 104(a)(1)) and furnish certain documents to the Secretary of Labor upon request (section 104(a)(6)), and authorize the Secretary of Labor to collect information and data from employee benefit plans for research and analysis (section 513).

(d) *Examples.* (1) A welfare plan has 25 participants at the beginning of the plan year. It is part of a group insurance arrangement of a trade association which provides benefits to employees of two or more unaffiliated employers, but not in connection with a multiemployer plan as defined in the Act. Plan benefits are fully insured pursuant to insurance contracts purchased with premium payments derived half from employee contributions (which the employer forwards within three months of receipt) and half from the general assets of each participating employer. Refunds to the plan are paid to participating employees within three months of receipt as provided in the plan and as described to each participant upon entering the plan. The trade association holds the insurance contracts. A trust acts as a conduit for payments, receiving premium payments from participating employers and paying the insurance company. The plan appoints the trade association as its plan administrator. The association, as plan administrator, provides summary plan descriptions to participants and beneficiaries, enlisting the help of participating employers in carrying out this distribution. The plan administrator also makes copies of certain plan documents available to the plan's principal office and such other places as necessary to give participants reasonable access to them. The plan administrator files with the Secretary an annual report covering activities of the plan, as required by the Act and such regulations as the Secretary may issue. The exemption provided by this section applies because the conditions of paragraph (b) have been satisfied.

(2) Assume the same facts as paragraph (d)(1) of this section except that the premium payments for the insurance company are paid from the trust to an independent insurance brokerage firm acting as the agent of the insurance company. The trade association is the holder of the insurance contract. The plan appoints an officer of the participating employer as the plan administrator. The officer, as plan administrator, performs the same reporting and disclosure functions as the administrator in paragraph (d)(1) of this section, enlisting the help of the association in providing summary plan descriptions and necessary information. The exemption provided by this section applies.

(3) The facts are the same as paragraph (d)(1) of this section except the welfare plan has 125 participants at the beginning of the plan year. The exemption provided by this section does not apply because the plan had 100 or more participants at the beginning of the plan year. See, however, § 2520.104–43.

(4) The facts are the same as paragraph (d)(2) of this section except the welfare plan has 125 participants. The exemption provided by this section does not apply because the plan had 100 or more participants at the beginning of the plan year. See, however, § 2520.104–43.

(e) *Applicability date.* For purposes of paragraph (b)(3) of this section, the arrangement may continue to use an entity (such as a trade association) as the conduit for the payment of insurance premiums to the insurance company

for reporting years of the arrangement beginning before January 1, 2001.

[43 FR 10149, Mar. 10, 1978, as amended at 65 FR 21084, Apr. 19, 2000; 67 FR 776, Jan. 7, 2002]

§ 2520.104–22 Exemption from reporting and disclosure requirements for apprenticeship and training plans.

(a) An employee welfare benefit plan that provides exclusively apprenticeship training benefits or other training benefits or that provides exclusively apprenticeship and training benefits shall not be required to meet any requirement of part 1 of the Act, provided that the administrator of such plan:

(1) Has filed with the Secretary the notice described in paragraph (b) of this section;

(2) Takes steps reasonably designed to ensure that the information required to be contained in such notice is disclosed to employees of employers contributing to the plan who may be eligible to enroll in any course of study sponsored or established by the plan; and

(3) Makes such notice available to such employees upon request.

(b) The notice referred to in paragraph (a) of this section shall contain accurate information concerning:

(1) The name of the plan;

(2) The Employer Identification Number (EIN) of the plan sponsor;

(3) The name of the plan administrator;

(4) The name and location of an office or person from whom an interested individual can obtain:

(i) A description of any existing or anticipated future course of study sponsored or established by the plan, including any prerequisites for enrolling in such course; and

(ii) A description of the procedure by which to enroll in such course.

(c) *Filing address*. The notice referred to in paragraph (a) of this section shall be filed with the Secretary of Labor by mailing it to: Apprenticeship and Training Plan Exemption, Pension and Welfare Benefits Administration, Room N–5644, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, or by delivering it during normal working hours to the Division of Reports, Office of Program Services, Pension and Welfare Benefits Administration, Room N–5644, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC.

[45 FR 15529, Mar. 11, 1980, as amended at 45 FR 27933, Apr. 25, 1980; 54 FR 8629, Mar. 1, 1989]

§ 2520.104–23 Alternative method of compliance for pension plans for certain selected employees.

(a) *Purpose and scope*. (1) This section contains an alternative method of compliance with the reporting and disclosure requirements of part 1 of title I of the Employee Retirement Income Security Act of 1974 for unfunded or insured pension plans maintained by an employer for a select group of management or highly compensated employees, pursuant to the authority of the Secretary of Labor under section 110 of the Act (88 Stat. 851).

(2) Under section 110 of the Act, the Secretary is authorized to prescribe an alternative method for satisfying any requirement of part 1 of title I of the Act with respect to any pension plans, or class of pension plans, subject to such requirement.

(b) *Filing obligation*. Under the authority of section 110 of the Act, an alternative form of compliance with the reporting and disclosure requirements of part 1 of the Act is provided for certain pension plans for a select group of management or highly compensated employees. The administrator of a pension plan described in paragraph (d) shall be deemed to satisfy the reporting and disclosure provisions of part 1 of title I of the Act by—

(1) Filing a statement with the Secretary of Labor that includes the name and address of the employer, the employer identification number (EIN) assigned by the Internal Revenue Service, a declaration that the employer maintains a plan or plans primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, and a statement of the number of such plans and the number of employees in each, and

(2) Providing plan documents, if any, to the Secretary upon request as required by section 104(a)(6) of the Act. Only one statement need be filed for

each employer maintaining one or more of the plans described in paragraph (d) of this section. For plans in existence on May 4, 1975, the statement shall be filed on or before August 31, 1975. For a plan to which part 1 of title I of the Act becomes applicable after May 4, 1975, the statement shall be filed within 120 days after the plan becomes subject to part 1.

(c) *Filing address.* Statements may be filed with the Secretary of Labor by mailing them addressed to: Top Hat Plan Exemption, Pension and Welfare Benefits Administration, Room N–5644, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, or by delivering it during normal working hours to the Division of Reports, Office of Program Services, Pension and Welfare Benefits Administration, Room N–5644, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC.

(d) *Application.* The alternative form of compliance described in paragraph (b) of this section is available only to employee pension benefit plans—

(1) Which are maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, and

(2) For which benefits (i) are paid as needed solely from the general assets of the employer, (ii) are provided exclusively through insurance contracts or policies, the premiums for which are paid directly by the employer from its general assets, issued by an insurance company or similar organization which is qualified to do business in any State, or (iii) both.

[40 FR 34533, Aug. 15, 1975, as amended at 54 FR 8629, Mar. 1, 1989; 67 FR 776, Jan. 7, 2002]

§ 2520.104–24 Exemption for welfare plans for certain selected employees.

(a) *Purpose and scope.* (1) This section, under the authority of section 104(a)(3) of the Employee Retirement Income Security Act of 1974, exempts unfunded or insured welfare plans maintained by an employer for the purpose of providing benefits for a select group of management or highly compensated employees from the reporting and disclosure provisions of part 1 of title I of the Act, except for the requirement to provide plan documents to the Secretary of Labor upon request under section 104(a)(1) of the Act.

(2) Under section 104(a)(3) of the Act, the Secretary is authorized to exempt by regulation any welfare benefit plan from all or part of the reporting and disclosure requirements of title I of the Act.

(b) *Exemption.* Under the authority of section 104(a)(3) of the Act, each employee welfare benefit plan described in paragraph (c) of this section is exempted from the reporting and disclosure provisions of part 1 of title I of the Act, except for providing plan documents to the Secretary of Labor upon request as required by section 104(a)(6).

(c) *Application.* This exemption is available only to employee welfare benefit plans:

(1) Which are maintained by an employer primarily for the purpose of providing benefits for a select group of management or highly compensated employees, and

(2) For which benefits (i) are paid as needed solely from the general assets of the employer, (ii) are provided exclusively through insurance contracts or policies, the premiums for which are paid directly by the employer from its general assets, issued by an insurance company or similar organization which is qualified to do business in any State, or (iii) both.

[40 FR 34533, Aug. 15, 1975, as amended at 67 FR 776, Jan. 7, 2002]

§ 2520.104–25 Exemption from reporting and disclosure for day care centers.

Under the authority of section 104(a)(3) of the Act, day care centers are exempted from the reporting and disclosure provisions of part 1 of title I of the Act, except for providing plan documents to the Secretary upon request as required under section 104(a)(6) of the Act.

[40 FR 34533, Aug. 15, 1975, as amended at 67 FR 776, Jan. 7, 2002]

§ 2520.104–26 Limited exemption for certain unfunded dues financed welfare plans maintained by employee organizations.

(a) *Scope*. Under the authority of section 104(a)(3) of the Act, a welfare benefit plan that meets the requirements of paragraph (b) of this section is exempted from the provisions of the Act that require filing with the Secretary an annual report and furnishing a summary annual report to participants and beneficiaries. Such plans may use a simplified method of reporting and disclosure to comply with the requirement to furnish a summary plan description to participants and beneficiaries, as follows:

(1) In lieu of filing an annual report with the Secretary or distributing a summary annual report, a filing is made of Report Form LM–2 or LM–3, pursuant to the Labor-Management Reporting and Disclosure Act (LMRDA) and regulations thereunder, and

(2) In lieu of a summary plan description, the employee organization constitution or by-laws may be furnished in accordance with § 2520.104b–2 to participants and beneficiaries together with any supplement to such document necessary to meet the requirements of §§ 2520.102–2 and 2520.102–3.

(b) *Application*. This exemption is available only to welfare benefit plans maintained by an employee organization, as that term is defined in section 3(4) of the Act, paid for out of the employee organization's general assets, which are derived wholly or partly from membership dues, and which cover employee organization members and their beneficiaries.

(c) *Limitations*. This exemption does not exempt the administrator from any other requirement of part 1 of title I of the Act.

[42 FR 37184, July 19, 1977, as amended at 67 FR 776, Jan. 7, 2002]

§ 2520.104–27 Alternative method of compliance for certain unfunded dues financed pension plans maintained by employee organizations.

(a) *Scope*. Under the authority of section 110 of the Act, a pension benefit plan that meets the requirements of paragraph (b) of this section is exempted from the provisions of the Act that require filing with the Secretary an annual report and furnishing a summary annual report to participants and beneficiaries receiving benefits. Such plans may use a simplified method of reporting and disclosure to comply with the requirement to furnish a summary plan description to participants and beneficiaries receiving benefits, as follows:

(1) In lieu of filing an annual report with the Secretary or distributing a summary annual report, a filing is made of Report Form LM–2 or LM–3, pursuant to the Labor-Management Reporting and Disclosure Act (LMRDA) and regulations thereunder, and

(2) In lieu of a summary plan description, the employee organization constitution or bylaws may be furnished in accordance with § 2520.104b–2 to participants and beneficiaries together with any supplement to such document necessary to meet the requirements of §§ 2520.102–2 and 2520.102–3.

(b) *Application*. This exemption is available only to pension benefit plans maintained by an employee organization, as that term is defined in section 3(4) of the Act, paid for out of the employee organization's general assets, which are derived wholly or partly from membership dues, and which cover employee organization members and their beneficiaries.

(c) *Limitations*. This exemption does not exempt the administrator from any other requirement of part 1 of title I of the Act.

[42 FR 37184, July 19, 1977, as amended at 67 FR 777, Jan. 7, 2002]

§ 2520.104–28 [Reserved]

§ 2520.104–41 Simplified annual reporting requirements for plans with fewer than 100 participants.

(a) *General*. (1) Under the authority of section 104(a)(2)(A), the Secretary of Labor may prescribe simplified annual reporting for employee pension benefit plans with fewer than 100 participants.

(2) Under the authority of section 104(a)(3), the Secretary of Labor may provide a limited exemption for any employee welfare benefit plan with respect to certain annual reporting requirements.

(b) *Application*. The administrator of an employee pension or welfare benefit plan which covers fewer than 100 participants at the beginning of the plan year and the administrator of an employee pension or welfare benefit plan described in § 2520.103–1(d) may file the simplified annual report described in paragraph (c) of this section in lieu of the annual report described in § 2520.103–1(b).

(c) *Contents*. The administrator of an employee pension or welfare benefit plan described in paragraph (b) of this section shall file, in the manner prescribed in § 2520.104a–5, a completed Form 5500 ''Annual Return/Report of Employee Benefit Plan,'' including any required schedules or statements prescribed by the instructions to the form, and, unless waived by § 2520.104–46, a report of an independent qualified public accountant meeting the requirements of § 2520.103–1(b).

[43 FR 10150, Mar. 10, 1978, as amended at 45 FR 51446, Aug. 1, 1980; 54 FR 8629, Mar. 1, 1989; 65 FR 21084, Apr. 19, 2000; 65 FR 62973, Oct. 19, 2000]

§ 2520.104–42 Waiver of certain actuarial information in the annual report.

Under the authority of section 104(a)(2)(A) of ERISA, the requirement of section 103(d)(6) of ERISA that the annual report include as part of the actuarial statement (Schedule B)[1] the present value of all of the plan's liabilities for nonforfeitable pension benefits allocated by termination priority categories, as set forth in section 4044 of title IV of ERISA, and the actuarial assumptions used in these computations, is waived.

[44 FR 5446, Jan. 26, 1979]

§ 2520.104–43 Exemption from annual reporting requirement for certain group insurance arrangements.

(a) *General*. Under the authority of section 104(a)(3) of the Act, the administrator of an employee welfare benefit plan which meets the requirements of paragraph (b) of this section is not required to file an annual report with the Secretary of Labor as required by section 104(a)(1) of the Act.

(b) *Application*. (1) This exemption applies only to a welfare plan for a plan year in which (i) such plan meets the requirements of § 2520.104–21, except the requirement that the plan cover fewer than 100 participants at the beginning of the plan year, and

(ii) An annual report containing the items set forth in § 2520.103–2 has been filed with the Secretary of Labor in accordance with § 2520.104a–6 by the trust or other entity which is the holder of the group insurance contracts by which plan benefits are provided.

(2) For purposes of this section, the terms ''group insurance arrangement'' or ''trust or other entity'' shall be used in place of the terms ''plan'' and ''plan administrator,'' as applicable, in §§ 2520.103–3, 2520.103–4, 2520.103–6, 2520.103–8, 2520.103–9 and 2520.103–10.

(c) *Limitation*. This provision does not exempt the administrator of an employee benefit plan which meets the requirements of paragraph (b) from furnishing a copy of a summary annual report to participants and beneficiaries of the plan, as required by section 104(b)(3) of the Act.

[43 FR 10150, Mar. 10, 1978, as amended at 65 FR 21084, Apr. 19, 2000; 67 FR 777, Jan. 7, 2002]

§ 2520.104–44 Limited exemption and alternative method of compliance for annual reporting by unfunded plans and by certain insured plans.

(a) *General*. (1) Under the authority of section 104(a)(3) of the Act, the Secretary of Labor may exempt an employee welfare benefit plan from any or all of the reporting and disclosure requirements of title I. An employee welfare benefit plan which meets the requirements of paragraph (b)(1) of this section is not required to comply with the annual reporting requirements described in paragraph (c) of this section.

(2) Under the authority of section 110 of the Act, an alternative method of compliance is prescribed for certain employee pension benefit plans subject to part 1, title I of the Act. An employee pension benefit plan which meets the requirements of paragraph

[1] Schedule B was filed as part of the original document.

(b)(2) or (b)(3) of this section is not required to comply with the annual reporting requirements described in paragraph (c) of this section.

(b) *Application.* This section applies only to:

(1) An employee welfare benefit plan under the terms of which benefits are to be paid—

(i) Solely from the general assets of the employer or employee organization maintaining the plan;

(ii) The benefits of which are provided exclusively through insurance contracts or policies issued by an insurance company or similar organization which is qualified to do business in any State or through a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e–9(d), the premiums for which are paid directly by the employer or employee organization from its general assets or partly from its general assets and partly from contributions by its employees or members, provided that any plan assets held by such an insurance company are held solely in the general account of such company or organization, contributions by participants are forwarded by the employer or employee organization within three months of receipt and, in the case of a plan that provides for the return of refunds to contributing participants, such refunds are returned to them within three months of receipt by the employer or employee organization, or

(iii) Partly in the manner specified in paragraph (b)(1)(i) of this section and partly in the manner specified in paragraph (b)(1)(ii) of this section;

(2) A pension benefit plan the benefits of which are provided exclusively through allocated insurance contracts or policies which are issued by, and pursuant to the specific terms of such contracts or policies benefit payments are fully guaranteed by an insurance company or similar organization which is qualified to do business in any State, and the premiums for which are paid directly by the employer or employee organization from its general assets or partly from its general assets and partly from contributions by its employees or members: *Provided,* That contributions by participants are forwarded by the employer or employee organization to the insurance company or organization within three months of receipt and, in the case of a plan that provides for the return of refunds to contributing participants, such refunds are returned to them within three months of receipt by the employer or employee organization; and

(3) A pension plan using a tax deferred annuity arrangement under section 403(b)(1) of the Internal Revenue Code (Title 26 of the United States Code) and/or a custodial account for regulated investment company stock under Code section 403(b)(7) as the sole funding vehicle for providing pension benefits.

(c) *Contents.* An employee benefit plan described in paragraph (b) of this section is exempt from complying with the following annual reporting requirements:

(1) Completing certain items of the annual report relating to financial information and transactions entered into by the plan as described in the instructions to the Form 5500 ''Annual Return/Report of Employee Benefit Plan'' and accompanying schedules;

(2) Engaging an independent qualified public accountant pursuant to section 103(a)(3)(A) of the Act and § 2520.103–1(b) to conduct an examination of the financial statements and schedules of the plan; and

(3) Including in the annual report a report of an independent qualified public accountant concerning the financial statements and schedules required to be a part of the annual report pursuant to section 103(b) of the Act and § 2520.103–1(b).

(d) *Limitation.* This section does not exempt any plan from filing an annual report form with the Secretary in accordance with section 104(a)(1) of the Act and § 2520.104a–5.

(e) *Example.* A welfare plan which is funded entirely with insurance contracts and which meets all the requirements of exemption under § 2520.104–20 except that it covers 100 or more participants at the beginning of the plan year is not exempt from the annual reporting requirements under § 2520.104–20, but is exempt from certain reporting requirements under § 2520.104–44. Under the latter section, such a welfare

plan should file Form 5500, including Schedule A ''Insurance Information.'' However, the plan is not required to engage an independent qualified public accountant and need not complete certain items on form 5500.

[43 FR 10150, Mar. 10, 1978, as amended at 45 FR 51446, Aug. 1, 1980; 46 FR 5884, Jan. 21, 1981; 65 FR 21085, Apr. 19, 2000; 67 FR 777, Jan. 7, 2002]

§ 2520.104–45 [Reserved]

§ 2520.104–46 Waiver of examination and report of an independent qualified public accountant for employee benefit plans with fewer than 100 participants.

(a) *General.* (1) Under the authority of section 103(a)(3)(A) of the Act, the Secretary may waive the requirements of section 103(a)(3)(A) in the case of a plan for which simplified annual reporting has been prescribed in accordance with section 104(a)(2) of the Act.

(2) Under the authority of section 104(a)(3) of the Act the Secretary may exempt any employee welfare benefit plan from certain annual reporting requirements.

(b) *Application.* (1)(i) The administrator of an employee pension benefit plan for which simplified annual reporting has been prescribed in accordance with section 104(a)(2)(A) of the Act and § 2520.104–41 is not required to comply with the annual reporting requirements described in paragraph (c) of this section, provided that with respect to each plan year for which the waiver is claimed—

(A)(*1*) At least 95 percent of the assets of the plan constitute qualifying plan assets within the meaning of paragraph (b)(1)(ii) of this section, or

(*2*) Any person who handles assets of the plan that do not constitute qualifying plan assets is bonded in accordance with the requirements of section 412 of the Act and the regulations issued thereunder, except that the amount of the bond shall not be less than the value of such assets;

(B) The summary annual report, described in § 2520.104b–10, includes, in addition to any other required information:

(*1*) Except for qualifying plan assets described in paragraph (b)(1)(ii)(A), (B) and (F) of this section, the name of each regulated financial institution holding (or issuing) qualifying plan assets and the amount of such assets reported by the institution as of the end of the plan year;

(*2*) The name of the surety company issuing the bond, if the plan has more than 5% of its assets in non-qualifying plan assets;

(*3*) A notice indicating that participants and beneficiaries may, upon request and without charge, examine, or receive copies of, evidence of the required bond and statements received from the regulated financial institutions describing the qualifying plan assets; and

(*4*) A notice stating that participants and beneficiaries should contact the Regional Office of the U.S. Department of Labor's Pension and Welfare Benefits Administration if they are unable to examine or obtain copies of the regulated financial institution statements or evidence of the required bond, if applicable; and

(C) in response to a request from any participant or beneficiary, the administrator, without charge to the participant or beneficiary, makes available for examination, or upon request furnishes copies of, each regulated financial institution statement and evidence of any bond required by paragraph (b)(1)(i)(A)(*2*).

(ii) For purposes of paragraph (b)(1), the term ''qualifying plan assets'' means:

(A) Qualifying employer securities, as defined in section 407(d)(5) of the Act and the regulations issued thereunder;

(B) Any loan meeting the requirements of section 408(b)(1) of the Act and the regulations issued thereunder;

(C) Any assets held by any of the following institutions:

(*1*) A bank or similar financial institution as defined in § 2550.408b–4(c);

(*2*) An insurance company qualified to do business under the laws of a state;

(*3*) An organization registered as a broker-dealer under the Securities Exchange Act of 1934; or

(*4*) Any other organization authorized to act as a trustee for individual retirement accounts under section 408 of the Internal Revenue Code.

(D) Shares issued by an investment company registered under the Investment Company Act of 1940;

(E) Investment and annuity contracts issued by any insurance company qualified to do business under the laws of a state; and,

(F) In the case of an individual account plan, any assets in the individual account of a participant or beneficiary over which the participant or beneficiary has the opportunity to exercise control and with respect to which the participant or beneficiary is furnished, at least annually, a statement from a regulated financial institution referred to in paragraphs (b)(1)(ii)(C), (D) or (E) of this section describing the assets held (or issued) by such institution and the amount of such assets.

(iii)(A) For purposes of this paragraph (b)(1), the determination of the percentage of all plan assets consisting of qualifying plan assets with respect to a given plan year shall be made in the same manner as the amount of the bond is determined pursuant to §§ 2580.412–11, 2580.412–14, and 2580.412–15.

(B) *Examples*. Plan A, which reports on a calendar year basis, has total assets of $600,000 as of the end of the 1999 plan year. Plan A's assets, as of the end of year, include: investments in various bank, insurance company and mutual fund products of $520,000; investments in qualifying employer securities of $40,000; participant loans, meeting the requirements of ERISA section 408(b)(1), totaling $20,000; and a $20,000 investment in a real estate limited partnership. Because the only asset of the plan that does not constitute a ''qualifying plan asset'' is the $20,000 real estate investment and that investment represents less than 5% of the plan's total assets, no bond would be required under the proposal as a condition for the waiver for the 2000 plan year. By contrast, Plan B also has total assets of $600,000 as of the end of the 1999 plan year, of which $558,000 constitutes ''qualifying plan assets'' and $42,000 constitutes non-qualifying plan assets. Because 7%—more than 5%—of Plan B's assets do not constitute ''qualifying plan assets,'' Plan B, as a condition to electing the waiver for the 2000 plan year, must ensure that it has a fidelity bond in an amount equal to at least $42,000 covering persons handling non-qualifying plan assets. Inasmuch as compliance with section 412 requires the amount of bonds to be not less than 10% of the amount of all the plan's funds or other property handled, the bond acquired for section 412 purposes may be adequate to cover the non-qualifying plan assets without an increase (i.e., if the amount of the bond determined to be needed for the relevant persons for section 412 purposes is at least $42,000). As demonstrated by the foregoing example, where a plan has more than 5% of its assets in non-qualifying plan assets, the bond required by the proposal is for the total amount of the non-qualifying plan assets, not just the amount in excess of 5%.

(2) The administrator of an employee welfare benefit plan that covers fewer than 100 participants at the beginning of the plan year is not required to comply with annual reporting requirements described in paragraph (c) of this section.

(c) *Waiver*. The administrator of a plan described in paragraph (b)(1) or (2) of this section is not required to:

(1) Engage an independent qualified public accountant to conduct an examination of the financial statements of the plan;

(2) Include within the annual report the financial statements and schedules prescribed in section 103(b) of the Act and §§ 2520.103–1, 2520.103–2, and 2520.103–10; and

(3) Include within the annual report a report of an independent qualified public accountant as prescribed in section 103(a)(3)(A) of the Act and § 2520.103–1.

(d) *Limitations*. (1) The waiver described in this section does not affect the obligation of a plan described in paragraph (b) (1) or (2) of this section to file a Form 5500 ''Annual Return/Report of Employee Benefit Plan,'' including any required schedules or statements prescribed by the instructions to the form. See § 2520.104–41.

(2) For purposes of this section, an employee pension benefit plan for which simplified annual reporting has been prescribed includes an employee pension benefit plan which elects to file a Form 5500 as a small plan pursuant to § 2520.103–1(d) with respect to the

plan year for which the waiver is claimed. See § 2520.104–41.

(3) For purposes of this section, an employee welfare benefit plan that covers fewer than 100 participants at the beginning of the plan year includes an employee welfare benefit plan which elects to file a Form 5500 as a small plan pursuant to § 2520.103–1(d) with respect to the plan year for which the waiver is claimed. See § 2520.104–41.

(4) A plan that elects to file a Form 5500 as a large plan pursuant to § 2520.103–1(d) may not claim a waiver under this section.

[43 FR 10151, Mar. 10, 1978, as amended at 43 FR 14010, Apr. 4, 1978; 45 FR 51447, Aug. 1, 1980; 54 FR 8629, Mar. 1, 1989; 65 FR 21085, Apr. 19, 2000; 65 FR 62973, Oct. 19, 2000]

§ 2520.104–47 Limited exemption and alternative method of compliance for filing of insurance company financial reports.

An administrator of an employee benefit plan to which section 103(e)(2) of the Act applies shall be deemed in compliance with the requirement to include with its annual report a copy of the financial report of the insurance company, insurance service or similar organization, provided that the administrator files a copy of such report within 45 days of receipt of a written request for such report by the Secretary of Labor.

[45 FR 14034, Mar. 4, 1980]

§ 2520.104–48 Alternative method of compliance for model simplified employee pensions—IRS Form 5305–SEP.

Under the authority of section 110 of the Act the provisions of this section are prescribed as an alternative method of compliance with the reporting and disclosure requirements set forth in part 1 of title I of the Employee Retirement Income Security Act of 1974 in the case of a simplified employee pension (SEP) described in section 408(k) of the Internal Revenue Code of 1954 as amended (the Code) that is created by use without modification of Internal Revenue Service (IRS) Form *5305–SEP*.

(a) At the time an employee becomes eligible to participate in the SEP (whether at the creation of the SEP or thereafter), the administrator of the SEP (generally the employer establishing and maintaining the SEP) shall furnish the employee with a copy of the completed and unmodified IRS Form *5305–SEP* used to create the SEP, including (1) the completed Contribution Agreement, (2) the General Information and Guidelines, and (3) the Questions and Answers.

(b) Following the end of each calendar year the administrator of the SEP shall notify each participant in the SEP in writing of any employer contributions made under the Contribution Agreement to the participant's individual retirement account or individual retirement annuity (IRA) for that year.

(c) If the employer establishing and maintaining the SEP selects, recommends, or in any other way influences employees to choose a particular IRA or type of IRA into which contributions under the SEP will be made, and if that IRA is subject to restrictions on a participant's ability to withdraw funds (other than restrictions imposed by the Code that apply to all IRAs), the administrator of the SEP shall give to each employee, in writing, within 90 days of the adoption of this regulation or at the time such employee becomes eligible to participate in the SEP, whichever is later, a clear explanation of those restrictions and a statement to the effect that other IRAs, into which rollovers or employee contributions may be made, may not be subject to such restrictions.

[45 FR 24869, Apr. 11, 1980]

§ 2520.104–49 Alternative method of compliance for certain simplified employee pensions.

Under the authority of section 110 of the Act, the provisions of this section are prescribed as an alternative method of compliance with the reporting and disclosure requirements set forth in part 1 of title I of the Act for a simplified employee pension (SEP) described in section 408(k) of the Internal Revenue Code of 1954 as amended, except for:

A SEP that is created by proper use of Internal Revenue Service Form *5305–SEP*, or; a SEP in connection with which the employer who establishes or

maintains the SEP selects, recommends or influences its employees to choose the IRAs into which employer contributions will be made and those IRAs are subject to provisions that prohibit withdrawal of funds by participants for any period of time.

(a) At the time an employee becomes eligible to participate in the SEP (whether at the creation of the SEP or thereafter) or up to 90 days after the effective date of this regulation, whichever is later, the administrator of the SEP (generally the employer establishing or maintaining the SEP) shall furnish the employee in writing with:

(1) Specific information concerning the SEP, including:

(i) The requirements for employee participation in the SEP,

(ii) The formula to be used to allocate employer contributions made under the SEP to each participant's individual retirement account or annuity (IRA),

(iii) The name or title of the individual who is designated by the employer to provide additional information to participants concerning the SEP, and

(iv) If the employer who establishes or maintains the SEP selects, recommends or substantially influences its employees to choose the IRAs into which employer contributions under the SEP will be made, a clear explanation of the terms of those IRAs, such as the rate(s) of return and any restrictions on a participant's ability to roll over or withdraw funds from the IRAs, including restrictions that allow rollovers or withdrawals but reduce earnings of the IRAs or impose other penalties.

(2) General information concerning SEPs and IRAs, including a clear explanation of:

(i) What a SEP is and how it operates,

(ii) The statutory provisions prohibiting discrimination in favor of highly compensated employees,

(iii) A participant's right to receive contributions under a SEP-and the allowable sources of contributions to a SEP-related IRA (SEP–IRA),

(iv) The statutory limits on contributions to SEP–IRAs,

(v) The consequences of excess contributions to a SEP–IRA and how to avoid excess contributions,

(vi) A participant's rights with respect to contributions made under a SEP to his or her IRA(s),

(vii) How a participant must treat contributions to a SEP–IRA for tax purposes,

(viii) The statutory provisions concerning withdrawal of funds from a SEP–IRA and the consequences of a premature withdrawal, and

(ix) A participant's ability to roll over or transfer funds from a SEP–IRA to another IRA, SEP–IRA, or retirement bond, and how such a rollover or transfer may be effected without causing adverse tax consequences.

(3) A statement to the effect that:

(i) IRAs other than the IRA(s) into which employer contributions will be made under the SEP may provide different rates of return and may have different terms concerning, among other things, transfers and withdrawals of funds from the IRA(s),

(ii) In the event a participant is entitled to make a contribution or rollover to an IRA, such contribution or rollover can be made to an IRA other than the one into which employer contributions under the SEP are to be made, and

(iii) Depending on the terms of the IRA into which employer contributions are made, a participant may be able to make rollovers or transfers of funds from that IRA to another IRA.

(4) A description of the disclosure required by the Internal Revenue Service to be made to individuals for whose benefit an IRA is established by the financial institution or other person who sponsors the IRA(s) into which contributions will be made under the SEP.

(5) A statement that, in addition to the information provided to an employee at the time he or she becomes eligible to participate in a SEP, the administrator of the SEP must furnish each participant:

(i) Within 30 days of the effective date of any amendment to the terms of the SEP, a copy of the amendment and a clear written explanation of its effects, and

(ii) No later than the later of:

(A) January 31 of the year following the year for which a contribution is made,

(B) 30 days after a contribution is made, or

(C) 30 days after the effective date of this regulation

written notification of any employer contributions made under the SEP to that participant's IRA(s).

(6) In the case of a SEP that provides for integration with Social Security

(i) A statement that Social Security taxes paid by the employer on account of a participant will be considered as an employer contribution under the SEP to a participant's SEP–IRA for purposes of determining the amount contributed to the SEP–IRA(s) of a participant by the employer pursuant to the allocation formula,

(ii) A description of the effect that integration with Social Security would have on employer contributions under a SEP, and

(iii) The integration formula, which may constitute part of the allocation formula required by paragraph (a)(1)(ii) of this section.

(b)(1) The requirements of paragraphs (a)(1)(i), (ii), (iii) and (a)(6)(i) of this regulation may be met by furnishing the SEP agreement to participants, provided that the SEP agreement is written in a manner reasonably calculated to be understood by the average plan participant.

(2) The requirements of paragraph (a)(1)(iv) of this regulation may be met through disclosure materials furnished by the financial institution in which the participant's IRA is maintained, provided the materials contain the information specified in such paragraph.

(c) No later than the later of:

(1) January 31 of the year following the year for which a contribution is made,

(2) 30 days after a contribution is made, or

(3) 30 days after the effective date of this regulation

the administrator of the SEP shall notify a participant in the SEP in writing of any employer contributions made under the SEP to the participant's IRA(s).

(d) Within 30 days of the effective date of any amendment to the terms of the SEP, the administrator shall furnish each participant a copy of the amendment and a clear explanation in writing of its effect.

[46 FR 1264, Jan. 6, 1981]

§ 2520.104–50 Short plan years, deferral of accountant's examination and report.

(a) *Definition of ''short plan year.''* For purposes of this section, a short plan year is a plan year, as defined in section 3(39) of the Act, of seven or fewer months' duration, which occurs in the event that:

(1) A plan is established or commences operations;

(2) A plan is merged or consolidated with another plan or plans;

(3) A plan is terminated; or

(4) The annual date on which the plan year begins is changed.

(b) *Deferral of accountant's report.* A plan administrator is not required to include the report of an independent qualified public accountant in the annual report for the first of two consecutive plan years, one of which is a short plan year, provided that the following conditions are satisfied:

(1) The annual report for the first of the two consecutive plan years shall include:

(i) Financial statements and accompanying schedules prepared in conformity with the requirements of section 103(b) of the Act and regulations promulgated thereunder;

(ii) An explanation why one of the two plan years is of seven or fewer months' duration; and

(iii) A statement that the annual report for the immediately following plan year will include a report of an independent qualified public accountant with respect to the financial statements and accompanying schedules for both of the two plan years.

(2) The annual report for the second of the two consecutive plan years shall include:

(i) Financial statements and accompanying schedules prepared in conformity with section 103(b) of the Act and regulations promulgated thereunder with respect to both plan years;

(ii) A report of an independent qualified public accountant with respect to

the financial statements and accompanying schedules for both plan years; and

(iii) A statement identifying any material differences between the unaudited financial information relating to, and contained in the annual report for, the first of the two consecutive plan years and the audited financial information relating to that plan year contained in the annual report for the immediately following plan year.

(c) *Accountant's examination and report*. The examination by the accountant which serves as the basis for the portion of his report relating to the first of the two consecutive plan years may be conducted at the same time as the examination which serves as the basis for the portion of his report relating to the immediately following plan year. The report of the accountant shall be prepared in conformity with section 103(a)(3)(A) of the Act and regulations thereunder.

[46 FR 1265, Jan. 6, 1981]

Subpart E—Reporting Requirements

(The information collection requirements contained in subpart E were approved by the Office of Management and Budget under control number 1210–0016)

§ 2520.104a–1 Filing with the Secretary of Labor.

(a) *General reporting requirements*. Part 1 of title I of the Act requires that the administrator of an employee benefit plan subject to the provisions of part 1 file with the Secretary of Labor certain reports and additional documents. Each report filed shall accurately and comprehensively detail the information required. Where a form is prescribed, the reports shall be filed on that form. The Secretary may reject any incomplete filing. Reports and documents shall be filed as specified in this part.

(b) *Exemption for certain welfare plans*. See §§ 2520.104–20, 2520.104–21, 2520.104–22, 2520.104–24, and 2520.104–25.

(c) *Alternative method of compliance for pension plans for certain selected employees*. See § 2520.104–23.

[42 FR 37185, July 19, 1977]

§§ 2520.104a–2—2520.104a–4 [Reserved]

§ 2520.104a–5 Annual reporting filing requirements.

(a) *Filing obligation*. Except as provided in § 2520.104a–6, the administrator of an employee benefit plan required to file an annual report pursuant to section 104(a)(1) of the Act shall file an annual report containing the items prescribed in § 2520.103–1 within:

(1) [Reserved]

(2) Seven months after the close of any plan year which begins after December 31, 1975, unless extended. See ''When to file'' instructions of the appropriate Annual Return/Report Form.

(b) *Where to file*. The annual report described in § 2520.103–1 shall be filed in accordance with and at the address provided in the instructions to the Annual Return/Report Form.

[43 FR 10152, Mar. 10, 1978; 43 FR 14010, Apr. 4, 1978; 67 FR 777, Jan. 7, 2002]

§ 2520.104a–6 Annual reporting for plans which are part of a group insurance arrangement.

(a) *General*. A trust or other entity described in § 2520.104–43(b) that files an annual report in accordance with the terms of subsections (b) and (c) shall be deemed to have filed such report in accordance with § 2520.104a–6 for purposes of § 2520.104–43.

(b) *Date of filing*. The annual report shall be filed within:

(1) Eleven and one-half months after the close of the fiscal year of the trust or other entity described in § 2520.104–43 which begins in 1975 or December 15, 1977, whichever is later; and

(2) Seven months after the close of the fiscal year of the trust or other entity which begins after December 31, 1975, unless extended. See ''When to file'' instructions of the appropriate Annual Return/Report Form.

(c) *Where to file*. The annual report prescribed in § 2520.103–2 shall be filed in accordance with and at the address provided in the instructions to the Annual Return/Report Form.

[43 FR 10152, Mar. 10, 1978; 43 FR 14010, Apr. 4, 1978]

§ 2520.104a–7 [Reserved]

§ 2520.104a–8 Requirement to furnish documents to the Secretary of Labor on request.

(a) *In general.* (1) Under section 104(a)(6) of the Act, the administrator of an employee benefit plan subject to the provisions of part 1 of title I of the Act is required to furnish to the Secretary, upon request, any documents relating to the employee benefit plan. For purposes of section 104(a)(6) of the Act, the administrator of an employee benefit plan shall furnish to the Secretary, upon service of a written request, a copy of:

(i) The latest updated summary plan description (including any summaries of material modifications to the plan or changes in the information required to be included in the summary plan description); and

(ii) Any other document described in section 104(b)(4) of the Act with respect to which a participant or beneficiary has requested, in writing, a copy from the plan administrator and which the administrator has failed or refused to furnish to the participant or beneficiary.

(2) *Multiple requests for document(s).* Multiple requests under this section for the same or similar document or documents shall be considered separate requests for purposes of § 2560.502c–6(a).

(b) For purposes of this section, a participant or beneficiary will include any individual who is:

(1) A participant or beneficiary within the meaning of ERISA sections 3(7) and 3(8), respectively;

(2) An alternate payee under a qualified domestic relations order (see ERISA section 206(d)(3)(K)) or prospective alternate payee (spouses, former spouses, children or other dependents);

(3) A qualified beneficiary under COBRA (see ERISA section 607(3)) or prospective qualified beneficiary (spouse or dependent child);

(4) An alternate recipient under a qualified medical child support order (see ERISA section 609(a)(2)(C)) or a prospective alternate recipient; or

(5) A representative of any of the foregoing.

(c) *Service of request.* Requests under this section shall be served in accordance with § 2560.502c–6(i).

(d) *Furnishing documents.* A document shall be deemed to be furnished to the Secretary on the date the document is received by the Department of Labor at the address specified in the request; or, if a document is delivered by certified mail, the date on which the document is mailed to the Department of Labor at the address specified in the request.

[67 FR 784, Jan. 7, 2002]

Subpart F—Disclosure Requirements

(The information collection requirements contained in subpart F were approved by the Office of Management and Budget under control number 1210–0016)

§ 2520.104b–1 Disclosure.

(a) *General disclosure requirements.* The administrator of an employee benefit plan covered by part 1 of title I of the Act must disclose certain material, including reports, statements and documents, to participants and beneficiaries. Disclosure under part 1 takes three forms. First, the plan administrator must, by direct operation of law, furnish certain material to all participants covered under the plan and beneficiaries receiving benefits under the plan (other than beneficiaries under a welfare plan) at stated times or if certain events occur. Second, the plan administrator must furnish certain material to individual participants and beneficiaries upon their request. Third, the plan administrator must make certain material available to participants and beneficiaries for inspection at reasonable times and places.

(b) *Fulfilling the disclosure obligation.* (1) Where certain material, including reports, statements and documents, is required under part 1 of the Act and this part to be furnished either by direct operation of law or on individual request, the plan administrator shall use measures reasonably calculated to ensure actual receipt of the material by plan participants and beneficiaries. Material which is required to be furnished to all participants covered

under the plan and beneficiaries receiving benefits under the plan (other than beneficiaries under a welfare plan) must be sent by a method or methods of delivery likely to result in full distribution. For example, in-hand delivery to an employee at his or her worksite is acceptable. However, in no case is it acceptable merely to place copies of the material in a location frequented by participants. It is also acceptable to furnish such material as a special insert in a periodical distributed to employees such as a union newspaper or a company publication if the distribution list for the periodical is comprehensive and up-to-date and a prominent notice on the front page of the periodical advises readers that the issue contains an insert with important information about rights under the plan and the Act which should be read and retained for future reference. If some participants and beneficiaries are not on the mailing list, a periodical must be used in conjunction with other methods of distribution such that the methods taken together are reasonably calculated to ensure actual receipt. Material distributed through the mail may be sent by first, second, or third-class mail. However, distribution by second or third-class mail is acceptable only if return and forwarding postage is guaranteed and address correction is requested. Any material sent by second or third-class mail which is returned with an address correction shall be sent again by first-class mail or personally delivered to the participant at his or her worksite.

(2) For purposes of section 104(b)(4) of the Act, materials furnished upon written request shall be mailed to an address provided by the requesting participant or beneficiary or personally delivered to the participant or beneficiary.

(3) For purposes of section 104(b)(2) of the Act, where certain documents are required to be made available for examination by participants and beneficiaries in the principal office of the plan administrator and in such other places as may be necessary to make available all pertinent information to all participants and beneficiaries, disclosure shall be made pursuant to the provisions of this paragraph. Such documents must be current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries. Plan administrators shall make copies of the latest annual report, and the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available at all times in their principal offices. They are not required to maintain these plan documents at all times at each employer establishment or union hall or office as described in paragraphs (b)(3)(i), (ii), and (iii) of this section, but the documents must be made available at any such location within ten calendar days following the day on which a request for disclosure at that location is made. Plan administrators shall make plan documents available at the appropriate employer establishment or union meeting hall or office within the required ten day period when a request is made directly to the plan administrator or through a procedure establishing reasonable rules governing the making of requests for examination of plan documents. If a plan administrator prescribes such a procedure and communicates it to plan participants and beneficiaries, a plan administrator will not be required to comply with a request made in a manner which does not conform to the established procedure. In order to comply with the requirements of this section, a procedure for making requests to examine plan documents must permit requests to be made in a reasonably convenient manner both directly to the plan administrator and at each employer establishment, or union meeting hall or office where documents must be made available in accordance with this paragraph. If no such reasonable procedure is established, a good faith effort by a participant or beneficiary to request examination of plan documents will be deemed a request to the plan administrator for purposes of this paragraph.

(i) In the case of a plan not maintained according to a collective bargaining agreement, including a plan maintained by a single employer with

more than one establishment, a multiple employer plan, and a plan maintained by a controlled group of corporations (within the meaning of section 1563(a) of the Internal Revenue Code of 1954 (the Code)), determined without regard to section 1563(a)(4) and (e)(3)(C) of the Code), documents shall be made available for examination in the principal office of the employer and at each employer establishment in which at least 50 participants covered under a plan are customarily working. ''Establishment'' means a single physical location where business is conducted or where services or industrial operations are performed. Where employees are engaged in activities which are physically dispersed, such as agriculture, construction, transportation and communications, the ''establishment'' shall be the place to which employees report each day. When employees do not usually work at, or report to, a single establishment—for example, traveling salesmen, technicians, and engineers—the establishment shall be the location from which the employees customarily carry out their activities—for example the field office of an engineering firm servicing at least 50 participants covered under the plan.

(ii) In the case of a plan maintained solely by an employee organization, the plan administrator shall take measures to ensure that documents are available for examination at the meeting hall or office of each union local in which there are at least 50 participants covered under the plan. Such measures shall include distributing copies of the documents to each union local in which there are at least 50 participants covered under the plan.

(iii) In the case of a plan maintained according to a collective bargaining agreement, including a collectively bargained single employer plan with more than one establishment, a collectively bargained multiple employer plan, and a multiemployer plan which meets the definition of section 3(37) of the Act, § 2510.3–37 of this chapter, and section 414(b) of the Internal Revenue Code of 1954 and 26 CFR 1.414(f) (40 FR 43034), documents shall be made available for examination in the principal office of the employee organization and at each employer establishment in which at least 50 participants covered under the plan are customarily working. In employment situations where employees do not usually work at, or report to, a single establishment, the plan administrator shall take measures to ensure that plan documents are available for examination at the meeting hall or office of each union local in which there are at least 50 participants covered under the plan.

(c) *Disclosure through electronic media.* (1) The administrator of a group health plan furnishing documents described in section 104(b)(1) of the Act through electronic media will be deemed to satisfy the requirements of paragraph (b)(1) of this section with respect to participants described in paragraph (c)(2) of this section if:

(i) The administrator takes appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt by participants of transmitted information and documents (e.g., uses return-receipt electronic mail feature or conducts periodic reviews or surveys to confirm receipt of transmitted information);

(ii) Electronically delivered documents are prepared and furnished in a manner consistent with the applicable style, format and content requirements (See 29 CFR 2520.102–2 through 2520.102–5);

(iii) Each participant is provided notice, through electronic means or in writing, apprising the participant of the document(s) to be furnished electronically, the significance of the document (e.g., the document describes changes in the benefits provided by your plan) and the participant's right to request and receive, free of charge, a paper copy of each such document; and

(iv) Upon request of any participant, the administrator furnishes, free of charge, a paper copy of any document delivered to the participant through electronic media.

(2) For purposes of paragraph (c)(1) of this section, the furnishing of documents through electronic media satisfies the requirements of paragraph (b)(1) of this section only with respect to participants:

(i) Who have the ability to effectively access at their worksite documents furnished in electronic form; and

(ii) Who have the opportunity at their worksite location to readily convert furnished documents from electronic form to paper form free of charge.

(3) This paragraph (c) applies on or after June 1, 1997.

(d) *Participant and beneficiary status for purposes of section 101(a) and 104(b)(1) of the Act and subpart F of this part.* See §§ 2510.3–3(d)(1), 2510.3–3(d)(2) and 2520.3–3(d)(3) of this chapter.

(Approved by the Office of Management and Budget under control number 1210–0039)

[42 FR 37186, July 19, 1977, as amended at 62 FR 16985, Apr. 8, 1997; 62 FR 36205, July 7, 1997; 67 FR 777, Jan. 7, 2002]

EFFECTIVE DATE NOTE: At 67 FR 17274, Apr. 9, 2002, § 2520.104b–1 is amended by revising the first sentence of paragraph (a), the first sentence of paragraph (b)(1), and paragraph (c), and adding a new paragraph (e), effective Oct. 9, 2002. For the convenience of the user, the revised and added text is set forth as follows:

§ 2520.104b–1 Disclosure.

(a) *General disclosure requirements.* The administrator of an employee benefit plan covered by Title I of the Act must disclose certain material, including reports, statements, notices, and other documents, to participants, beneficiaries and other specified individuals. Disclosure under Title I of the Act generally takes three forms. * * *

(b) *Fulfilling the disclosure obligation.* (1) Except as provided in paragraph (e) of this section, where certain material, including reports, statements, notices and other documents, is required under Title I of the Act, or regulations issued thereunder, to be furnished either by direct operation of law or on individual request, the plan administrator shall use measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals. * * *

* * * * *

(c) *Disclosure through electronic media.* (1) Except as otherwise provided by applicable law, rule or regulation, the administrator of an employee benefit plan furnishing documents through electronic media is deemed to satisfy the requirements of paragraph (b)(1) of this section with respect to an individual described in paragraph (c)(2) if:

(i) The administrator takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents—

(A) Results in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information); and

(B) Protects the confidentiality of personal information relating to the individual's accounts and benefits (e.g., incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

(ii) The electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document;

(iii) Notice is provided to each participant, beneficiary or other individual, in electronic or non-electronic form, at the time a document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes changes in the benefits provided by your plan) and of the right to request and obtain a paper version of such document; and

(iv) Upon request, the participant, beneficiary or other individual is furnished a paper version of the electronically furnished documents.

(2) Paragraph (c)(1) shall only apply with respect to the following individuals:

(i) A participant who—

(A) Has the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform his or her duties as an employee; and

(B) With respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties; or

(ii) A participant, beneficiary or any other person entitled to documents under Title I of the Act or regulations issued thereunder (including, but not limited to, an ''alternate payee'' within the meaning of section 206(d)(3) of the Act and a ''qualified beneficiary'' within the meaning of section 607(3) of the Act) who—

(A) Except as provided in paragraph (c)(2)(ii) (B) of this section, has affirmatively consented, in electronic or non-electronic form, to receiving documents through electronic media and has not withdrawn such consent;

(B) In the case of documents to be furnished through the Internet or other electronic communication network, has affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used to provide the information that is the subject of the consent, and has provided an address for the receipt of electronically furnished documents;

(C) Prior to consenting, is provided, in electronic or non-electronic form, a clear and conspicuous statement indicating:

(1) The types of documents to which the consent would apply;

(2) That consent can be withdrawn at any time without charge;

(3) The procedures for withdrawing consent and for updating the participant's, beneficiary's or other individual's address for receipt of electronically furnished documents or other information;

(4) The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and

(5) Any hardware and software requirements for accessing and retaining the documents; and

(D) Following consent, if a change in hardware or software requirements needed to access or retain electronic documents creates a material risk that the individual will be unable to access or retain electronically furnished documents:

(1) Is provided with a statement of the revised hardware or software requirements for access to and retention of electronically furnished documents;

(2) Is given the right to withdraw consent without charge and without the imposition of any condition or consequence that was not disclosed at the time of the initial consent; and

(3) Again consents, in accordance with the requirements of paragraph (c)(2)(ii)(A) or paragraph (c)(2)(ii)(B) of this section, as applicable, to the receipt of documents through electronic media.

* * * * *

(e) *Limitations.* This section does not apply to disclosures required under provisions of part 2 and part 3 of the Act over which the Secretary of the Treasury has interpretative and regulatory authority pursuant to Reorganization Plan No. 4 of 1978.

§ 2520.104b–2 Summary plan description.

(a) *Obligation to furnish.* Under the authority of sections 104(b)(1) and 104(c) of the Act, the plan administrator of an employee benefit plan subject to the provisions of part 1 of title I shall furnish a copy of the summary plan description and a statement of ERISA rights as provided in § 2520.102–3(t), to each participant covered under the plan (as defined in § 2510.3–3(d)), and each beneficiary receiving benefits under a pension plan on or before the later of:

(1) The date which is 90 days after the employee becomes a participant, or (in the case of a beneficiary receiving benefits under a pension plan) within 90 days after he or she first receives benefits, except as provided in § 2520.104b–4(a), or,

(2) Within 120 days after the plan becomes subject to part 1 of title I.

(3)(i) A plan becomes subject to part 1 of title I on the first day on which an employee is credited with an hour of service under § 2530.200b–2 or § 2530.200b–3. Where a plan is made prospectively effective to take effect after a certain date or after a condition is satisfied, the day upon which the plan becomes subject to part 1 of title I is the day after such date or condition is satisfied. Where a plan is adopted with a retroactive effective date, the 120 day period begins on the day after the plan is adopted. Where a plan is made retroactively effective dependent on a condition, the day on which the plan becomes subject to part 1 of title I is the day after the day on which the condition is satisfied. Where a plan is made retroactively effective subject to a contingency which may or may not occur in the future, the day on which the plan becomes subject to part 1, title I is the day after the day on which the contingency occurs.

(ii) Examples: Company A is negotiating the purchase of Company B. On September 1, 1978, as part of the negotiations, Company A adopts a pension plan covering the employees of Company B, contingent on the successful conclusion of its negotiations to purchase Company B. The plan provides that it shall take effect on the first day of the calendar year in which the purchase is concluded. On February 1, 1979, the negotiations conclude with Company A's purchase of Company B. The plan therefore becomes effective on

February 1, 1979, retroactive to January 1, 1979. The summary plan description must be filed and disclosed no later than 120 days after February 1, 1979.

(b) *Periods for furnishing updated summary plan description.* (1) For purposes of the requirement to furnish the updated summary plan description to each participant and each beneficiary receiving benefits under the plan (other than beneficiaries receiving benefits under a welfare plan) required by section 104(b)(1) of the Act, the administrator of an employee benefit plan shall furnish such updated summary plan description no later than 210 days following the end of the plan year which occurs five years after the last date a change in the information required to be disclosed by section 102 or 29 CFR 2520.102–3 would have been reflected in the most recently distributed summary plan description (or updated summary plan description) as described in section 102 of the Act.

(2) In the case of a plan to which no amendments have been made between the end of the time period covered by the last distributed summary plan description (or updated summary plan description), described in section 102 of the Act, and the next occurring applicable date described in paragraph (b)(1) of this section, for purposes of the requirement to furnish the updated summary plan description to each participant, and to each beneficiary receiving benefits under the plan (other than beneficiaries receiving benefits under a welfare plan), required by section 104(b)(1) of the Act, the administrator of an employee benefit plan shall furnish such updated summary plan description no later than 210 days following the end of the plan year which occurs ten years after the last date a change in the information required to be disclosed by section 102 or 29 CFR 2520.102–3 would have been reflected in the most recently distributed summary plan description (or updated summary plan description), as described in section 102 of the Act.

(c)–(f) [Reserved]

(g) *Terminated plans.* (1) If, on or before the date by which a plan is required to furnish a summary plan description or updated summary plan description to participants and pension plan beneficiaries under this section, the plan has terminated within the meaning of paragraph (g)(2) of this section, the administrator of such plan is not required to furnish to participants covered under the plan or to beneficiaries receiving benefits under the plan a summary plan description.

(2) For purposes of this section, a plan shall be considered terminated if:

(i) In the case of an employee pension benefit plan, all distributions to participants and beneficiaries have been completed; and

(ii) In the case of an employee welfare benefit plan, no claims can be incurred which will result in a liability of the plan to pay benefits. A claim is incurred upon the occurrence of the event or condition from which the claim arises (whether or not discovered).

(h) [Reserved]

(i) *Style and format of the summary plan description.* See § 2520.102–2.

(j) *Contents of the summary plan description.* See § 2520.102–3.

(k) *Option for different summary plan descriptions.* See § 2520.102–4; § 2520.104–26; and § 2520.104–27.

(l) *Employee benefit plan—participant covered under a plan.* See § 2510.3–3(d).

[42 FR 37187, July 19, 1977, as amended at 45 FR 14032, Mar. 4, 1980; 48 FR 1714, Jan. 14, 1983; 61 FR 33849, 33850, July 1, 1996; 67 FR 777, Jan. 7, 2002]

§ 2520.104b–3 Summary of material modifications to the plan and changes in the information required to be included in the summary plan description.

(a) The administrator of an employee benefit plan subject to the provisions of part 1 of title I of the Act shall, in accordance with § 2520.104b–1(b), furnish a summary description of any material modification to the plan and any change in the information required by section 102(b) of the Act and § 2520.102–3 of these regulations to be included in the summary plan description to each participant covered under the plan and each beneficiary receiving benefits under the plan. Except as provided in paragraph (d) of this section, the plan administrator shall furnish this summary, written in a manner calculated

to be understood by the average plan participant, not later than 210 days after the close of the plan year in which the modification or change was adopted. This disclosure date is not affected by retroactive application to a prior plan year of an amendment which makes a material modification to the plan; a modification does not occur before it is adopted. For example, a calendar year plan adopts a modification in April, 1978. The modification, by its terms, applies retroactively to the 1977 plan year. A summary description of the material modification is furnished on or before July 29, 1979. A plan which adopts an amendment which makes a material modification to the plan which takes effect on a date in the future must disclose a summary of that modification within 210 days after the close of the plan year in which the modification or change is adopted. Under the authority of sections 104(a)(3) and 110 of the Act, a summary description of a material modification or change is not required to be disclosed if it is rescinded or otherwise does not take effect. For example, a calendar year plan adopts a modification in June, 1978. The modification, by its terms, becomes effective beginning in plan year 1979. Before the beginning of plan year 1979, the prospective modification is withdrawn. No summary of the material modification is required to be disclosed.

(b) The summary of material modifications to the plan or changes in information required to be included in the summary plan description need not be furnished separately if the changes or modifications are described in a timely summary plan description. For example, a calendar year plan adopts a material modification on June 3, 1976. The modification is incorporated in a summary plan description furnished on July 15, 1977. No separate summary of the material modification is furnished. The plan adopts another material modification September 15, 1977. A separate summary of the modification is furnished on or before July 29, 1978.

(c) The copy of the summary plan description furnished in accordance with §§ 2520.104b–2(a)(1)(i) and 2520.104b–4 shall be acompanied by all summaries of material modifications or changes in information required to be included in the summary plan description which have not been incorporated into that summary plan description.

(d) *Special rule for group health plans*—(1) *General*. Except as provided in paragraph (d)(2) of this section, the administrator of a group health plan, as defined in section 733(a)(1) of the Act, shall furnish to each participant covered under the plan a summary, written in a manner calculated to be understood by the average plan participant, of any modification to the plan or change in the information required to be included in the summary plan description, within the meaning of paragraph (a) of this section, that is a material reduction in covered services or benefits not later than 60 days after the date of adoption of the modification or change.

(2) *90-day alternative rule*. The administrator of a group health plan shall not be required to furnish a summary of any material reduction in covered services or benefits within the 60-day period described in paragraph (d)(1) of this section to any participant covered under the plan who would reasonably be expected to be furnished such summary in connection with a system of communication maintained by the plan sponsor or administrator, with respect to which plan participants are provided information concerning their plan, including modifications and changes thereto, at regular intervals of not more than 90 days and such communication otherwise meets the disclosure requirements of 29 CFR 2520.104b–1.

(3) *''Material reduction''*. (i) For purposes of this paragraph (d), a ''material reduction in covered services or benefits'' means any modification to the plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the plan.

(ii) A ''reduction in covered services or benefits'' generally would include any plan modification or change that: eliminates benefits payable under the

plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, deductibles, coinsurance, copayments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditions or requirements (*e.g.*, preauthorization requirements) to obtaining services or benefits under the plan.

(e) *Applicability date.* Paragraph (d) of this section is applicable as of the first day of the first plan year beginning after June 30, 1997.

(f)–(g) [Reserved]

(Approved by the Office of Management and Budget under control number 1210–0039)

[42 FR 37188, July 19, 1977, as amended at 62 FR 16985, Apr. 8, 1997; 62 FR 36205, July 7, 1997; 65 FR 70243, Nov. 21, 2000; 66 FR 34994, July 2, 2001; 67 FR 777, Jan. 7, 2002]

§ 2520.104b–4 Alternative methods of compliance for furnishing the summary plan description and summaries of material modifications of a pension plan to a retired participant, a separated participant with vested benefits, and a beneficiary receiving benefits.

Under the authority of section 110 of the Act, in the case of an employee pension benefit plan—

(a) *Summary plan descriptions.* A plan administrator will be deemed to satisfy the requirements of section 104(b)(1) of the Act and § 2520.104b–2(a) to furnish a copy of the initial summary plan description to a retired participant, a beneficiary receiving benefits, or a separated participant with vested benefits (''vested separated participant'') if, no earlier than the date stated in paragraph (a)(4) of this section,

(1) In the case of a retired participant or a beneficiary receiving benefits, a document is furnished which—

(i) Meets the requirements of §§ 2520.102–2 and 2520.102–3 except paragraphs (b)(3), (b)(4), (j), (k), (l), (n), (o) and (p);

(ii) Contains a statement that the benefit payment presently being received by the retired participant or beneficiary receiving benefits will continue in the same amount and for the period provided in the mode of settlement selected at retirement, and will not be changed except as described in paragraph (a)(1)(iii) of this section; and

(iii) Contains a statement describing any plan provision under which the present benefit payment may be reduced, changed, terminated, forfeited or suspended;

(2) In the case of a vested separated participant, a document is furnished which—

(i) Meets the requirements of §§ 2520.102–2 and 2520.102–3 except paragraphs (b)(3), (b)(4), (j), (l), (n), (o), (p) and (r);

(ii)(A) If at or after separation, a separated vested participant was furnished a statement of the dollar amount of the vested benefit or the method of computation of the benefit, includes a statement that the dollar amount of the vested benefit was previously furnished and that a copy of the previously furnished statement of the dollar amount of such vested benefit or method of computation of the benefit may be obtained from the plan upon request;

(B) If the vested separated participant was not furnished a statement of the dollar amount of the vested benefit or the method of computation of the benefit, the plan furnishes either a statement of the dollar amount of the vested benefit, or a statement of the formula used to determine the dollar amount of the vested benefit;

(iii) Includes a statement of the form in which the benefits will be paid and duration of the payment period or a description of the optional modes of payment available under the plan; and

(iv) Includes a statement describing any plan provision under which a benefit may be reduced, changed, terminated, forfeited or suspended; or

(3)(i) Such retired participant, vested separated participant, or beneficiary receiving benefits was furnished with a copy of a document which—

(A) Satisfies the requirements of section 102(a)(1) of the Act and § 2520.102–2 (relating to the style and format of the summary plan description) and § 2520.102–3 (relating to the content of the summary plan description);

(B) Describes the rights and obligations under the plan of such retired participant, vested separated participant, or beneficiary receiving benefits as of the date stated in subparagraph (4);

(ii) In the case of a person who retired, became a beneficiary, or separated with vested benefits before November 16, 1977, a document will be deemed to comply with the requirements of paragraph (a)(2)(i) of this section if the document omitted only information described in one or more of the provisions of § 2520.102–3 listed below, provided that a supplement containing such information, which meets the requirements of § 2520.102–2, is furnished to the retired participant, vested separated participant, or beneficiary receiving benefits by November 16, 1977.

(A) Employer identification number (EIN), as required by § 2520.102–3(c);

(B) Type of administration, as required by § 2520.102–3(e);

(C) Name of agent for service of legal process, as required by § 2520.102–3(g);

(D) Names and addresses of trustees, as required by § 2520.102–3(h);

(E) Statement regarding plan termination insurance as required by § 2520.102–3(m);

(F) Date of the end of the fiscal year, as required by § 2520.102–3(r); or

(G) Statement of ERISA rights, as required by § 2520.102–3(t).

(4) For purposes of this paragraph the dates are: For a vested separated participant, the date of separation; for a beneficiary, the date on which payment of benefits commences; and for a retired participant, the date of retirement.

(b) *Updated summary plan descriptions.* A copy of an updated summary plan description need not be furnished as prescribed in section 104(b)(1) of the Act and § 2520.104b–2(b) to a retired participant, vested separated participant, or a beneficiary receiving benefits if—

(1)(i) On or after the date stated in paragraph (b)(1)(ii) of this section, the retired participant, vested separated participant, or beneficiary is furnished with a copy of the most recent summary plan description and a copy of any summaries of material modifications not incorporated in such summary plan description;

(ii) For purposes of paragraph (b)(1)(i) of this section the dates are: for a retired participant, the date of retirement; for a vested separated participant, the date of separation; and for a beneficiary, the date on which payment of benefits commences;

(2) No latter than the date on which an updated summary plan description is furnished to participants and beneficiaries as prescribed by section 104(b)(1) of the Act and § 2520.104b–2(b), a retired participant, vested separated participant, or beneficiary receiving benefits is furnished a notice containing the following:

(i) A statement that the benefit rights of such retired participant, vested separated participant, or beneficiary receiving benefits are set forth in the earlier summary plan description and any subsequently furnished summaries of material modifications (*see* paragraph (c)), and

(ii) A statement that such retired participant, vested separated participant, or beneficiary receiving benefits may obtain a copy of the earlier summary plan description and summaries of material modifications described in paragraph (b)(2)(i) of this section, and the updated summary plan description, without charge, upon request, from the plan administrator; and

(3) The plan administrator furnishes a copy of the documents described in paragraph (b)(2)(ii) of this section to such retired participant, vested separated participant or beneficiary, without charge, upon request.

(c) *Summary of material modifications or changes.* A summary description of a material modification to the plan or a change in the information required to be included in the summary plan description need not be furnished to a retired participant, a vested separated participant or a beneficiary receiving benefits under the plan, within the time prescribed in section 104(b)(1) of the Act and § 2520.104b–3 for furnishing summary descriptions of such modifications and changes, if the material modification or change in no way affects such retired participant's, vested separated participant's, or beneficiary's rights under the plan. For example, a change in trustees is information which such a person may need to

know in order to make inquiries about his or her rights expeditiously, and hence must be furnished. On the other hand, a modification in benefits under the plan to which such retired participant, vested separated participant, or beneficiary had not at any time been entitled (and would not in the future be entitled) would not affect his or her rights and hence need not be furnished. If such retired participant, vested separated participant, or beneficiary requests a copy of a summary description of a material modification or a change which was not furnished, the plan administrator shall furnish the copy, without charge.

[45 FR 14032, Mar. 4, 1980, as amended at 61 FR 33850, July 1, 1996]

§ 2520.104b–10 Summary Annual Report.

(a) *Obligation to furnish.* Except as otherwise provided in paragraph (g) of this section, the administrator of any employee benefit plan shall furnish annually to each participant of such plan and to each beneficiary receiving benefits under such plan (other than beneficiaries under a welfare plan) a summary annual report conforming to the requirements of this section. Such furnishing of the summary annual report shall take place in accordance with the requirements of § 2520.104b–1 of this part.

(b) [Reserved]

(c) *When to furnish.* Except as otherwise provided in this paragraph (c), the summary annual report required by paragraph (a) of this section shall be furnished within nine months after the close of the plan year.

(1) In the case of a welfare plan described in § 2520.104–43 of this part, such furnishing shall take place within 9 months after the close of the fiscal year of the trust or other entity which files the annual report under § 2520.104a–6 of this part.

(2) When an extension of time in which to file an annual report has been granted by the Internal Revenue Service, such furnishing shall take place within 2 months after the close of the period for which the extension was granted.

(d) *Contents, style and format.* Except as otherwise provided in this paragraph (d), the summary annual report furnished to participants and beneficiaries of an employee pension benefit plan pursuant to this section shall consist of a completed copy of the form prescribed in paragraph (d)(3) of this section, and the summary annual report furnished to participants and beneficiaries of an employee welfare benefit plan pursuant to this section shall consist of a completed copy of the form prescribed in paragraph (d)(4) of this section. The information used to complete the form shall be based upon information contained in the most recent annual report of the plan which is required to be filed in accordance with section 104(a)(1) of the Act.

(1) Any portion of the forms set forth in this paragraph (d) which is not applicable to the plan to which the summary annual report relates, or which would require information which is not required to be reported on the annual report of that plan, may be omitted.

(2) Where the plan administrator determines that additional explanation of any information furnished pursuant to this paragraph (d) is necessary to fairly summarize the annual report, such explanation shall be set forth following the completed form required by this paragraph (d) and shall be headed, ''Additional Explanation.''

(3) *Form for Summary Annual Report Relating to Pension Plans.*

SUMMARY ANNUAL REPORT FOR (NAME OF PLAN)

This is a summary of the annual report for (name of plan and EIN) for (period covered by this report). The annual report has been filed with the Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the plan are provided by (indicate funding arrangements). Plan expenses were ($). These expenses included ($) in administrative expenses and ($) in benefits paid to participants and beneficiaries, and ($) in other expenses. A total of ( ) persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

[If the plan is funded other than solely by allocated insurance contracts:]

The value of plan assets, after subtracting liabilities of the plan, was ($) as of (the end of the plan year), compared to ($) as of (the beginning of the plan year). During the plan year the plan experienced an (increase) (decrease) in its net assets of ($) This (increase) (decrease) includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of ($), including employer contributions of ($), employee contributions of ($), (gains) (losses) of ($), from the sale of assets, and earnings from investments of ($).

[If any funds are used to purchase allocated insurance contracts:]

The plan has (a) contract(s) with (name of insurance carrier(s)) which allocate(s) funds toward (state whether individual policies, group deferred annuities or other). The total premiums paid for the plan year ending (date) were ($).

Minimum Funding Standards

[If the plan is a defined benefit plan:]

An actuary's statement shows that (enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA) (not enough money was contributed to the plan to keep it funded in accordance with the mimimum funding standards of ERISA. The amount of the deficit was $).

[If the plan is a defined contribution plan covered by funding requirements:]

(Enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA) (Not enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA. The amount of the deficit was $).

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report: [*Note*—list only those items which are actually included in the latest annual report]

1. an accountant's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan);
5. loans or other obligations in default or classified as uncollectible;
6. leases in default or classified as uncollectible;
7. transactions in excess of 5 percent of the plan assets;
8. insurance information including sales commissions paid by insurance carriers;
9. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103–12 investment entities in which the plan participates, and
10. actuarial information regarding the funding of the plan.

To obtain a copy of the full annual report, or any part thereof, write or call the office of (name), who is (state title: e.g., the plan administrator), (business address and telephone number). The charge to cover copying costs will be ($) for the full annual report, or ($) per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (address), (at any other location where the report is available for examination), and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N5638, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

(4) *Form for Summary Annual Report Relating to Welfare Plans.*

SUMMARY ANNUAL REPORT FOR (NAME OF PLAN)

This is a summary of the annual report of the (name of plan, EIN and type of welfare plan) for (period covered by this report). The annual report has been filed with the Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

[If any benefits under the plan are provided on an uninsured basis:]

(Name of sponsor) has committed itself to pay (all, certain) (state type of) claims incurred under the terms of the plan.

[If any of the funds are used to purchase insurance contracts:]

Insurance Information

The plan has (a) contract(s) with (name of insurance carrier(s)) to pay (all, certain) (state type of) claims incurred under the terms of the plan. The total premiums paid for the plan year ending (date) were ($ ____).

[If applicable add:]

Because (it is a) (they are) so called ''experience-rated'' contract(s), the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending (date), the premiums paid under such ''experience-rated'' contract(s) were ($) and the total of all benefit claims paid under the(se) experience-rated contract(s) during the plan year was ($).

[If any funds of the plan are held in trust or in a separately maintained fund:]

Basic financial statement

The value of plan assets, after subtracting liabilities of the plan, was ($) as of (the end of plan year), compared to ($) as of (the beginning of the plan year). During the plan year the plan experienced an (increase) (decrease) in its net assets of ($). This (increase) (decrease) includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of ($) including employer contributions of ($), employee contributions of ($), realized (gains) (losses) of ($) from the sale of assets, and earnings from investments of ($). Plan expenses were ($). These expenses included ($) in administrative expenses, ($) in benefits paid to participants and beneficiaries, and ($) in other expenses.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report: [Note—list only those items which are actually included in the latest annual report].

1. an accountant's report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan);
5. loans or other obligations in default or classified as uncollectible;
6. leases in default or classified as uncollectible;
7. transactions in excess of 5 percent of the plan assets;
8. insurance information including sales commissions paid by insurance carriers; and
9. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103–12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of (name), who is (state title: e.g., the plan administrator), (business address and telephone number). The charge to cover copying costs will be ($) for the full annual report, or ($) per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (address), (at any other location where the report is available for examination), and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N5638, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

(e) *Foreign languages*. In the case of either—

(1) A plan which covers fewer than 100 participants at the beginning of a plan year in which 25 percent or more of all plan participants are literate only in the same non-English language; or

(2) A plan which covers 100 or more participants in which 500 or more participants or 10 percent or more of all plan participants, whichever is less, are literate only in the same non-English language—

The plan administrator for such plan shall provide these participants with an English-language summary annual report which prominently displays a

notice, in the non-English language common to these participants, offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants. The notice offering assistance shall clearly set forth any procedures participants must follow to obtain such assistance.

(f) *Furnishing of additional documents to participants and beneficiaries.* A plan administrator shall promptly comply with any request by a participant or beneficiary for additional documents made in accordance with the procedures or rights described in paragraph (d) of this section.

(g) *Exemptions.* Notwithstanding the provisions of this section, a summary annual report is not required to be furnished with respect to the following:

(1) A totally unfunded welfare plan described in 29 CFR 2520.104–44(b)(1)(i);

(2) A welfare plan which meets the requirements of 29 CFR 2520.104–20(b);

(3) An apprenticeship or other training plan which meets the requirements of 29 CFR 2520.104–22;

(4) A pension plan for selected employees which meets the requirements of 29 CFR 2520.104–23;

(5) A welfare plan for selected employees which meets the requirements of 29 CFR 2520.104–24;

(6) A day care center referred to in 29 CFR 2520.104–25;

(7) A dues financed welfare plan which meets the requirements of 29 CFR 2520.104–26; and

(8) A dues financed pension plan which meets the requirements of 29 CFR 2520.104–27.

APPENDIX TO § 2520.104B–10—THE SUMMARY ANNUAL REPORT (SAR) UNDER ERISA: A CROSS-REFERENCE TO THE ANNUAL REPORT

SAR Item	Form 5500 Large Plan Filer Line Items	Form 5500 Small Plan Filer Line Items
A. PENSION PLAN		
1. Funding arrangement	Form 5500—9a	Same.
2. Total plan expenses	Sch. H—2j	Sch. I—2i.
3. Administrative expenses	Sch. H—2i(5)	Not applicable.
4. Benefits paid	Sch. H—2e(4)	Sch. I—2e.
5. Other expenses	Sch. H—Subtract the sum of 2e(4) & 2i(5) from 2j.	Sch. I—2h.
6. Total participants	Form 5500—7f	Same.
7. Value of plan assets (net):		
a. End of plan year	Sch. H—1l [Col. (b)]	Sch. I—1c [Col. (b)].
b. Beginning of plan year	Sch. H—1l [Col. (a)]	Sch. I—1c [Col. (a)].
8. Change in net assets	Sch. H—Subtract 1l [Col. (a)] from 1l[Col. (b)].	Sch. I—Subtract 1c [Col. (a) from 1c [Col. (b)].
9. Total income	Sch. H—2d	Sch. I—2d.
a. Employer contributions	Sch. H—2a(1)(A) & 2a(2) if applicable	Sch. I—2a(1) & 2b if applicable.
b. Employee contributions	Sch. H—2a(1)(B) & 2a(2) if applicable	Sch. I—2a(2) & 2b if applicable.
c. Gains (losses) from sale of assets	Sch. H—2b(4)(C)	Not applicable.
d. Earnings from investments	Sch. H—Subtract the sum of 2a(3), 2b(4)(C) and 2c from 2d.	Sch. I –2c.
10. Total insurance premiums	Total of all Schs. A –5b	Total of all Schs. A—5b.
11. Funding deficiency:		
a. Defined benefit plans	Sch. B—10	Same.
b. Defined contribution plans	Sch. R—6c, if more than zero	Same.
B. WELFARE PLAN		
1. Name of insurance carrier	All Schs. A—1(a)	Same.
2. Total (experience rated and non-experienced rated) insurance premiums.	All Schs. A—Sum of 8a(4) and 9(a)	Same.
3. Experience rated premiums	All Schs. A—8a(4)	Same.
4. Experience rated claims	All Schs. A—8b(4)	Same.
5. Value of plan assets (net):		
a. End of plan year	Sch. H—1l [Col. (b)]	Sch. I—1c [Col. (b)].
b. Beginning of plan year	Sch. H—1l [Col. (a)]	Sch. I—1c [Col. (a)].
6. Change in net assets	Sch. H—Subtract 1l [Col. (a)] from 1l [Col. (b)].	Sch. I—Subtract 1c [Col. (a)] from 1c [Col. (b)].
7. Total income	Sch. H—2d	Sch. I—2d.
a. Employer contributions	Sch. H—2a(1)(A) & 2a(2) if applicable	Sch. I—2a(1) & 2b if applicable.
b. Employee contributions	Sch. H—2a(1)(B) & 2a(2) if applicable	Sch. I—2a(2) & 2b if applicable.
c. Gains (losses) from sale of assets	Sch. H—2b(4)(C)	Not applicable.
d. Earnings from investments	Sch. H—Subtract the sum of 2a(3), 2b(4)(C) and 2c from 2d.	Sch. I –2c.

APPENDIX TO § 2520.104B–10—THE SUMMARY ANNUAL REPORT (SAR) UNDER ERISA: A CROSS-REFERENCE TO THE ANNUAL REPORT—Continued

SAR Item	Form 5500 Large Plan Filer Line Items	Form 5500 Small Plan Filer Line Items
8. Total plan expenses	Sch. H—2j	Sch. I—2i.
9. Administrative expenses	Sch. H—2i(5)	Not applicable.
10. Benefits paid	Sch. H—2e(4)	Sch. I—2e.
11. Other expenses	Sch. H—Subtract the sum of 2e(4) & 2i(5) from 2j.	Sch. I—2h.

[44 FR 19403, Apr. 3, 1979, as amended at 44 FR 31640, June 1, 1979; 47 FR 31873, July 23, 1982; 54 FR 8629, Mar. 1, 1989; 65 FR 21085, Apr. 19, 2000; 65 FR 35568, June 5, 2000]

§ 2520.104b–30 Charges for documents.

(a) *Application*. The plan administrator of an employee benefit plan may impose a reasonable charge to cover the cost of furnishing to participants and beneficiaries upon their written request as required under section 104(b)(4) of the Act, copies of the following information, statements or documents: The latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. No charge may be assessed for furnishing information, statements or documents as required by other provisions of the Act, which include, in part 1 of title I, sections 104(b)(1), (2), (3) and (c) and 105(a) and (c).

(b) *Reasonableness*. The charge assessed by the plan administrator to cover the costs of furnishing documents is reasonable if it is equal to the actual cost per page to the plan for the least expensive means of acceptable reproduction, but in no event may such charge exceed 25 cents per page. For example, if a plan printed a large number of pamphlets at $1.00 per 50-page pamphlet, the actual cost of reproduction for the entire pamphlet ($1.00) would be equal to 2 cents per page. If only one page of such a pamphlet were requested, the actual cost of providing that page from the printed copy would be $1.00, since the copy would no longer be complete. In such a case, the least expensive means of acceptable reproduction would be individually reproducing the page requested at a charge of no more than 25 cents. On the other hand, if six pages of the same plan document were requested and each page cost 20 cents to be reproduced, the actual cost of providing those pages would be $1.20. In such a case, if a printed copy is available, the least expensive means of acceptable reproduction would be to use pages from the printed copy at a charge of no more than $1.00. No other charge for furnishing documents, such as handling or postage charges, will be deemed reasonable. The plan administrator shall provide information to a plan participant or beneficiary, upon request, about the charge that would be made to provide a copy of material described in this paragraph.

[41 FR 16964, Apr. 23, 1976, as amended at 41 FR 37575, Sept. 7, 1976]

Subpart G—Recordkeeping Requirements

§ 2520.107–1 Use of electronic media for maintenance and retention of records.

(a) *Scope and purpose*. Sections 107 and 209 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), contain certain requirements relating to the maintenance of records for reporting and disclosure purposes and for determining the pension benefits to which participants and beneficiaries are or may become entitled. This section provides standards applicable to both pension and welfare plans concerning the use of electronic media for the maintenance and retention of records required to be kept under sections 107 and 209 of ERISA.

(b) *General requirements*. The record maintenance and retention requirements of sections 107 and 209 of ERISA are satisfied when using electronic media if:

(1) The electronic recordkeeping system has reasonable controls to ensure

the integrity, accuracy, authenticity and reliability of the records kept in electronic form;

(2) The electronic records are maintained in reasonable order and in a safe and accessible place, and in such manner as they may be readily inspected or examined (for example, the recordkeeping system should be capable of indexing, retaining, preserving, retrieving and reproducing the electronic records);

(3) The electronic records are readily convertible into legible and readable paper copy as may be needed to satisfy reporting and disclosure requirements or any other obligation under Title I of ERISA;

(4) The electronic recordkeeping system is not subject, in whole or in part, to any agreement or restriction that would, directly or indirectly, compromise or limit a person's ability to comply with any reporting and disclosure requirement or any other obligation under Title I of ERISA; and

(5) Adequate records management practices are established and implemented (for example, following procedures for labeling of electronically maintained or retained records, providing a secure storage environment, creating back-up electronic copies and selecting an off-site storage location, observing a quality assurance program evidenced by regular evaluations of the electronic recordkeeping system including periodic checks of electronically maintained or retained records, and retaining paper copies of records that cannot be clearly, accurately or completely transferred to an electronic recordkeeping system).

(c) *Legibility and readability*. All electronic records must exhibit a high degree of legibility and readability when displayed on a video display terminal or other method of electronic transmission and when reproduced in paper form. The term ''legibility'' means the observer must be able to identify all letters and numerals positively and quickly to the exclusion of all other letters or numerals. The term ''readability'' means that the observer must be able to recognize a group of letters or numerals as words or complete numbers.

(d) *Disposal of original paper records*. Original paper records may be disposed of any time after they are transferred to an electronic recordkeeping system that complies with the requirements of this section, except such original records may not be discarded if the electronic record would not constitute a duplicate or substitute record under the terms of the plan and applicable federal or state law.

[67 FR 17275, Apr. 9, 2002]

EFFECTIVE DATE NOTE: At 67 FR 17275, Apr. 9, 2002, subpart G to part 2520 was added, effective Oct. 9, 2002.

SUBCHAPTER D—MINIMUM STANDARDS FOR EMPLOYEE PENSION BENEFIT PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2530—RULES AND REGULATIONS FOR MINIMUM STANDARDS FOR EMPLOYEE PENSION BENEFIT PLANS

Subpart A—Scope and General Provisions

Sec.
2530.200a Scope.
2530.200a–1 Relationship of the Act and the Internal Revenue Code of 1954.
2530.200a–2 Treasury regulations for purposes of the Act.
2530.200a–3 Labor regulations for purposes of the Internal Revenue Code of 1954.
2530.200b–1 Computation periods.
2530.200b–2 Hour of service.
2530.200b–3 Determination of service to be credited to employees.
2530.200b–4 One-year break in service.
2530.200b–5 Seasonal industries. [Reserved]
2530.200b–6 Maritime industry.
2530.200b–7 Day of service for employees in the maritime industry.
2530.200b–8 Determination of days of service to be credited to maritime employees.
2530.201–1 Coverage; general.
2530.201–2 Plans covered by part 2530.

Subpart B—Participation, Vesting and Benefit Accrual

2530.202–1 Eligibility to participate; general.
2530.202–2 Eligibility computation period.
2530.203–1 Vesting; general.
2530.203–2 Vesting computation period.
2530.203–3 Suspension of pension benefits upon employment.
2530.204–1 Year of participation for benefit accrual.
2530.204–2 Accrual computation period.
2530.204–3 Alternative computation methods for benefit accrual.
2530.204–4 Deferral of benefit accrual.

Subpart C—Form and Payment of Benefits

2530.205—2530.206 [Reserved]

Subpart D—Plan Administration as Related to Benefits

2530.207—2530.209 [Reserved]
2530.210 Employer or employers maintaining the plan.

AUTHORITY: Secs. 201, 202, 203, 204, 210, 505, 1011, 1012, 1014 and 1015, Pub. L. 93–406, 88 Stat. 852–862, 866–867, 894, 898–913, 924–929 (29 U.S.C. 1051–4, 1060, 1135, 26 U.S.C. 410, 411, 413, 414); Secretary of Labor's Order No. 13–76.

SOURCE: 41 FR 56462, Dec. 28, 1976, unless otherwise noted.

Subpart A—Scope and General Provisions

§ 2530.200a Scope.

§ 2530.200a–1 Relationship of the Act and the Internal Revenue Code of 1954.

(a) Part 2 of title I of the Employee Retirement Income Security Act of 1974 (hereinafter referred to as ''the Act'') contains minimum standards that a plan which is an employee pension benefit plan within the meaning of section 3(2) of the Act and which is covered under part 2 must satisfy. (For a general explanation of the coverage of part 2, see § 2530.201–1.) Substantially identical requirements are imposed by subchapter D of chapter 1 of subtitle A of the Internal Revenue Code of 1954 (hereinafter referred to as ''the Code'') for plans seeking qualification for certain tax benefits under the Code. In general, the Code provisions apply to ''qualified'' pension, profit-sharing, and stock bonus plans described in section 401(a) of the Code, annuity plans described in section 403(a) of the Code and bond purchase plans described in section 405(a) of the Code. The standards contained in title I of the Act apply generally to both ''nonqualified' and ''qualified'' employee pension benefit plans. The standards contained in the Act, and the related Code provisions, are ''minimum'' standards. In general, more liberal plan provisions (in terms of the benefit to be derived by the employee) are not prohibited.

(b) For a definition of the term ''employee pension benefit plan'', see section 3(2) of the Act and § 2510.3–2.

(c) For a statement of the coverage of part 2 of the Act, see sections 4 and 201 of the Act and §§ 2510.3–2, 2510.3–3, 2530.201–1 and 2530.201–2.

§ 2530.200a–2 Treasury regulations for purposes of the Act.

Regulations prescribed by the Secretary of the Treasury or his delegate under sections 410 and 411 of the Code (relating to minimum standards for participation and vesting) shall apply for purposes of sections 202 through 204 of the Act. Thus, except for those provisions (such as the definition of an hour of service or a year of service) for which authority to prescribe regulations is specifically delegated to the Secretary of Labor, regulations prescribed by the Secretary of the Treasury shall also be used to implement the related provisions contained in the Act. Those regulations specify the credit that must be given to an employee for years of service and years of participation completed by the employee. The allocation of regulatory jurisdiction between the Secretary of Treasury or his delegate and the Secretary of Labor is governed by titles I through III of the Act. *See* section 3002 of the Act (88 Stat. 996).

§ 2530.200a–3 Labor regulations for purposes of the Internal Revenue Code of 1954.

The Secretary of Labor is specifically authorized to prescribe certain regulations (generally relating to hour of service, year of service, break in service, year of participation and special rules for seasonal and maritime industries) applicable to both title I of the Act and sections 410 and 411 of the Code. These regulations are contained in this subpart (A) and subpart B of this part (2530) and must be integrated with regulations prescribed by the Secretary of the Treasury or his delegate under sections 410 of the Code (relating to minimum participation standards), 411(a) of the Code (relating to minimum vesting standards) and 411(b) of the Code (relating to benefit accrual requirements). The allocation of regulatory jurisdiction between the Secretary of Labor and the Secretary of the Treasury or his delegate is governed by titles I through III of the Act. *See* section 3002 of the Act (88 Stat. 996).

§ 2530.200b–1 Computation periods.

(a) *General*. Under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code, an employee's statutory entitlements with regard to participation, vesting and benefit accrual are generally determined by reference to years of service and years of participation completed by the employee and one-year breaks in service incurred by the employee. The units used for determining an employee's credit towards statutory participation, vesting and benefit accrual entitlements are in turn defined in terms of the number of hours of service credited to the employee during a specified period—in general, a twelve-consecutive-month period—referred to herein as a ''computation period''. A plan must designate eligibility computation periods pursuant to § 2530.202–2 and vesting computation periods pursuant to § 2530.203–2, and, under certain circumstances, a defined benefit plan must designate accrual computation periods pursuant to § 2530.204–2. An employee who is credited with 1000 hours of service during an eligibility computation period must generally be credited with a year of service for purposes of section 202 of the Act and section 410 of the Code (relating to minimum participation standards). An employee who is credited with 1000 hours of service during a vesting computation period must generally be credited with a year of service for purposes of section 203 of the Act and 411(a) of the Code (relating to minimum vesting standards). An employee who completes 1000 hours of service during an accrual computation period must, under certain circumstances, be credited with at least a partial year of participation for purposes of section 204 of the Act and section 411(b) of the Code (relating to benefit accrual requirements). With respect to benefit accrual, however, the plan may not be required to credit an employee with a full year of participation and, therefore, full accrual for such year of participation unless the employee is credited with the number of hours of service or other permissible units of credit prescribed under the plan for crediting of a full year of participation (*see* § 2530.204–2 (c) and (d)). It should be noted that under some of the equivalencies which a plan may use under § 2530.200b–3 to determine the

number of units of service to be credited to an employee in a computation period, an employee must be credited with a year of service of partial year of participation if the employee is credited with a number of units of service which is less than 1000 in a computation period. *See also* § 2530.200b–9, relating to elapsed time.

(b) *Rules generally applicable to computation periods.* In general, employment at the beginning or the end of an applicable computation period or on any particular date during the computation period is not determinative of whether the employee is credited with a year of service or a partial year of participation, or incurs a break in service, for the computation period. Rather, these determinations generally must be made solely with reference to the number of hours (or other units of service) which are credited to the employee during the applicable computation period. For example, an employee who is credited with 1000 hours of service during any portion of a vesting computation period must be credited with a year of service for that computation period regardless of whether the employee is employed by the employer on the first or the last day of the computation period. It should be noted, however, that in certain circumstances, a plan may provide that certain consequences follow from an employee's failure to be employed on a particular date. For example, under section 202(a)(4) of the Act and section 410(a)(4) of the Code, a plan may provide that an individual otherwise entitled to commence participation in the plan on a specified date does not commence participation on that date if he or she was separated from the service before that date. Similary, under section 204(b)(1) of the Act and section 411(b)(1) of the Code, a plan which is not a defined benefit plan is not subject to section 204 (b)(1) and (b)(3) of the Act and section 411 (b)(1) and (b)(3) of the Code. Such a plan, therefore, may provide that an individual who has been a participant in the plan, but who has separated from service before the date on which the employer's contributions to the plan or forfeitures are allocated among participant's accounts or before the last day of the vesting computation period, does not share in the allocation of such contributions or forfeitures even though the individual is credited with 1000 or more hours of service for the applicable vesting computation period. Under certain circumstances, however, such a plan provision may result in discrimination prohibited under section 401(a)(4) of the Code. *See* Revenue Ruling 76–250, I.R.B. 1976–27.

§ 2530.200b–2 Hour of service.

(a) *General rule.* An hour of service which must, as a minimum, be counted for the purposes of determining a year of service, a year of participation for benefit accrual, a break in service and employment commencement date (or reemployment commencement date) under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code, is an hour of service as defined in paragraphs (a)(1), (2) and (3) of this section. The employer may round up hours at the end of a computation period or more frequently.

(1) An hour of service is each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer during the applicable computation period.

(2) An hour of service is each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Notwithstanding the preceding sentence,

(i) No more than 501 hours of service are required to be credited under this paragraph (a)(2) to an employee on account of any single continuous period during which the employee performs no duties (whether or not such period occurs in a single computation period);

(ii) An hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed is not required to be credited to the employee if such payment is made or due under a plan maintained solely for the purpose of complying with applicable

workmen's compensation, or unemployment compensation or disability insurance laws; and

(iii) Hours of service are not required to be credited for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

For purposes of this paragraph (a)(2), a payment shall be deemed to be made by or due from an employer regardless of whether such payment is made by or due from the employer directly, or indirectly through, among others, a trust fund, or insurer, to which the employer contributes or pays premiums and regardless of whether contributions made or due to the trust fund, insurer or other entity are for the benefit of particular employees or are on behalf of a group of employees in the aggregate.

(3) An hour of service is each hour for which back pay, irrespective of mitigation of damages, is either awarded or agreed to by the employer. The same hours of service shall not be credited both under paragraph (a)(1) or paragraph (a)(2), as the case may be, and under this paragraph (a)(3). Thus, for example, an employee who receives a back pay award following a determination that he or she was paid at an unlawful rate for hours of service previously credited will not be entitled to additional credit for the same hours of service. Crediting of hours of service for back pay awarded or agreed to with respect to periods described in paragraph (a)(2) shall be subject to the limitations set forth in that paragraph. For example, no more than 501 hours of service are required to be credited for payments of back pay, to the extent that such back pay is agreed to or awarded for a period of time during which an employee did not or would not have performed duties.

(b) *Special rule for determining hours of service for reasons other than the performance of duties.* In the case of a payment which is made or due on account of a period during which an employee performs no duties, and which results in the crediting of hours of service under paragraph (a)(2) of this section, or in the case of an award or agreement for back pay, to the extent that such award or agreement is made with respect to a period described in paragraph (a)(2) of this section, the number of hours of service to be credited shall be determined as follows:

(1) *Payments calculated on the basis of units of time.* (i) Except as provided in paragraph (b)(3) of this section, in case of a payment made or due which is calculated on the basis of units of time, such as hours, days, weeks or months, the number of hours of service to be credited shall be the number of regularly scheduled working hours included in the units of time on the basis of which the payment is calculated. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of hours to be credited on the basis of a 40-hour workweek or an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classifications, reasonably defined. Thus, for example, a plan may not use a 40-hour workweek as a basis for calculating the number of hours of service to be credited for periods of paid absences for one employee while using an average based on hours worked over a representative period of time as a basis for such calculation for another, similarly situated employee.

(ii) *Examples.* The following examples illustrate the rules in paragraph (b)(1) of this section without regard to paragraphs (b)(2) and (3).

(A) Employee A was paid for 6 hours of sick leave at his normal hourly rate. The payment was therefore calculated on the basis of units of time (hours). A must, therefore, be credited with 6 hours of service for the 6 hours of sick leave.

(B) Employee B was paid his normal weekly salary for 2 weeks of vacation. The payment was therefore calculated on the basis of units of time (weeks). B is scheduled to work 37½ hours per week (although from time to time working overtime). B must, therefore, be credited with 75 hours of service for the vacation (37½ hours per week multiplied by 2 weeks).

(C) Employee C spent 3 weeks on a paid vacation. C's salary is established at an annual rate but is paid on a biweekly basis. The amount of salary payments attributable to be paid vacation was calculated on the basis of units of time (weeks). C has no regular work schedule but works at least 50 hours per week. The plan provides for the calculation of hours of service to be credited to employees in C's situation for periods of paid absences on the basis of a 40-hour workweek. C must, therefore, be credited with 120 hours of service for the vacation (3 weeks multiplied by 40 hours per week).

(D) Employee D spent 2 weeks on vacation, for which he was paid $150. Although D has no regular work schedule, the $150 payment was established on the assumption that an employee in D's position works an average of 30 hours per week at a rate of $2.25 per hour. The payment of $150 was therefore calculated on the basis of units of time (weeks). The plan provides for the calculation of hours of service to be credited to employees in D's situation for periods of paid absences on the basis of the average number of hours worked by an employee over a period of 6 months. D's employer's records show that D worked an average of 28 hours per week for a 6-month period. D must, therefore, be credited with 56 hours of service for the vacation (28 hours per week multiplied by 2 weeks).

(E) Employee E is regularly scheduled to work a 40-hour week. During a computation period E is incapacitated as a result of injury for a period of 11 weeks. Under the sick leave policy of E's employer E is paid his normal weekly salary for the first 8 weeks of his incapacity. After 8 weeks the employer ceases to pay E's normal salary but, under a disability insurance program maintained by the employer, E receives payments equal to 65% of his normal weekly salary for the remaining 3 weeks during which E is incapacitated. For the period during which he is incapacitated, therefore, E receives credit for 440 hours of service (11 weeks multiplied by 40 hours per week) regardless of the fact that payments to E for the last 3 wseeks of the period during which hs was incapacitated were made in amounts less than E's normal compensation.

(2) *Payments not calculated on the basis of units of time.* (i) Except as provided in paragraph (b)(3) of this section, in the case of a payment made or due, which is not calculated on the basis of units of time, the number of hours of service to be credited shall be equal to the amount of the payment divided by the employee's most recent hourly ratre of compensation (as determined under paragraph (b)(2)(ii) of this section) before the period during which no duties are performed.

(ii) For purposes of paragraph (b)(2)(i) of this section an employee's hourly rate of compensation shall be determined as follows:

(A) In the case of an employee whose compensation is determined on the basis of an hourly rate, such hourly rate shall be the employee's most recent hourly rate of compensation.

(B) In the case of an employee whose compensation is determined on the basis of a fixed rate for specified periods of time (other than hours) such as days, weeks or months, the employee's hourly rate of compensation shall be the employee's most recent rate of compensation for a specified period of time (other than an hour), divided by the number of hours regularly scheduled for the performance of duties during such period of time. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, the plan may provide for the calculation of the employee's hourly rate of compensation on the basis of a 40-hour workweek, an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classificatons, reasonably defined.

(C) In the case of an employee whose compensation is not determined on the basis of a fixed rate for specified periods of time, the employee's hourly rate of compensation shall be the lowest hourly rate of compensation paid to employees in the same job classification as that of the employee or, if no

employees in the same job classification have an hourly rate, the minimum wage as established from time to time under section 6(a)(1) of the Fair Labor Standards Act of 1938, as amended.

(iii) *Examples*. The following examples illustrate the rules in paragraph (b)(2) of this section without regard to paragraphs (b)(1) and (3).

(A) As a result of an injury, an employee is incapacitated for 5 weeks. A lump sum payment of $500 is made to the employee with respect to the injury under a disability insurance plan maintained by the employee's employer. At the time of the injury, the employee's rate of pay was $3.00 per hour. The employee must, therefore, be credited with 167 hours of service ($500 divided by $3.00 per hour).

(B) Same facts as in Example (A), above, except that at the time of the injury, the employee's rate of pay was $160 per week and the employee has a regular work schedule of 40 hours per week. The employee's hourly rate of compensation is, therefore, $4.00 per hour ($160 per week divided by 40 hours per week) and the employee must be credited with 125 hours of service for the period of absence ($500 divided by $4.00 per hour).

(C) An employee is paid at an hourly rate of $3.00 per hour and works a regular schedule of 40 hours per week. The employee is disabled for 26 weeks during a computation period. For the first 12 weeks of disability, the employee is paid his normal weekly earnings of $120 per week by the employer. Thereupon, a lump-sum disability payment of $1000 is made to the employee under a disability insurance plan maintained by the employer. Under paragraph (a)(3)(i) of this section, the employee is credited with 501 hours of service for the period of disability (lesser of 501 hours—the maximum number of hours required to be credited for a period of absence—or the sum of 12 weeks multiplied by 40 hours per week plus $1000 divided by $3.00 per hour).

(3) *Rule against double credit*. (i) Nothwithstanding paragraphs (b)(1) and (2) of this section, an employee is not required to be credited on account of a period during which no duties are performed with a number of hours of service which is greater than the number of hours regularly scheduled for the performance of duties during such period. For purposes of applying the preceding sentence in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of hours of service to be credited to the employee for a period during which no duties are performed on the basis of a 40-hour workweek or an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(ii) *Examples*. (A) Employee A has a regular 40-hour workweek. Each year Employee A is entitled to pay for a two-week vacation, in addition to receiving normal wages for all hours worked, regardless of whether A actually takes a vacation and regardless of the duration of his vacation. The vacation payments are, therefore, calculated on the basis of units of time (weeks). In computation period I, A takes no vacation but receives vacation pay. A is entitled to no credit for hours of service for the vacation payment made in computation period I because the payment was not made on account of a period during which no duties were performed. In computation period II, A takes a vacation of one week in duration, although receiving pay for a two-week vacation. A is entitled to be credited with 40 hours of service for his one-week vacation in computation period II even though paid for two weeks of vacation. In computation period III, A takes a vacation for a period lasting more than 2 weeks. A is entitled to be credited with 80 hours of service for his vacation in computation period III (40 hours per week multiplied by 2 weeks) even though the vacation lasted more than 2 weeks.

(B) Employee B has no regular work schedule. As a result of an injury, B is incapacitated for 1 day. A lump-sum payment of $500 is made to A with respect to the injury under an insurance program maintained by the employer.

A pension plan maintained by the employer provides for the calculation of the number of hours of service to be credited to an employee without a regular work schedule on the basis of an 8-hour day. A is therefore required to be credited with no more than 8 hours for the day during which he was incapacitated, even though A's rate of pay immediately before the injury was $3.00 per hour.

(c) *Crediting of hours of service to computation periods.* (1) Except as provided in paragraph (c)(4) of this section, hours of service described in paragraph (a)(1) of this section shall be credited to the computation period in which the duties are performed.

(2) Except as provided in paragraph (c)(4) of this section, hours of service described in paragraph (a)(2) of this section shall be credited as follows:

(i) Hours of service credited to an employee on account of a payment which is calculated on the basis of units of time, such as hours, days, weeks or months, shall be credited to the computation period or computation periods in which the period during which no duties are performed occurs, beginning with the first unit of time to which the payment relates.

(ii) Hours of service credited to an employee by reason of a payment which is not calculated on the basis of units of time shall be credited to the computation period in which the period during which no duties are performed occurs, or if the period during which no duties are performed extends beyond one computation period, such hours of service shall be allocated between not more than the first two computation periods on any reasonable basis which is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(3) Except as provided in paragraph (c)(4) of this section, hours of service described in paragraph (a)(3) of this section shall be credited to the computation period or periods to which the award or agreement for back pay pertains, rather than to the computation period in which the award, agreement or payment is made.

(4) In the case of hours of service to be credited to an employee in connection with a period of no more than 31 days which extends beyond one computation period, all such hours of service may be credited to the first computation period or the second computation period. Crediting of hours of service under this paragraph must be done consistently with respect to all employees within the same job classifications, reasonably defined.

(5) *Examples.* The following examples are intended to illustrate paragraph (c)(4) of this section.

(i) An employer maintaining a plan pays employees on a bi-weekly basis. The plan designates the calendar year as the vesting computation period. The employer adopts the practice of crediting hours of service for the performance of duties during a bi-weekly payroll period to the vesting computation period in which the payroll period ends. Thus, when a payroll period ends on January 7, 1978, all hours of service to be credited to employees for the performance of duties during that payroll period are credited to the vesting computation period beginning on January 1, 1978. This practice is consistent with paragraph (c)(4) of this section, even though some hours of service credited to the computation period beginning on January 1, 1978, are attributable to duties performed during the previous vesting computation period.

(ii) An employer maintains a sick leave policy under which an employee is entitled to a certain number of hours of sick leave each year, on account of which the employee is paid his or her normal rate of compensation. An employee with a work schedule of 8 hours per day, 5 days per week, is sick from December 26, 1977 through January 4, 1978. Under the employer's sick leave policy, the employee is entitled to compensation for the entire period. A plan maintained by the employer establishes a calendar-year vesting computation period. The period from December 26, 1977 through December 31, 1977 includes 5 working days; the period from January 1, 1978 through January 4, 1978 includes 3 working days. Unless the plan adopts the alternative method for crediting service under paragraph (c)(4) of this section (illustrated in Example (iii), below) for the period of paid sick leave, the plan, pursuant to paragraph (c)(2)(i) of this section, must

credit the employee with 40 hours of service in the 1977 vesting computation period (5 days multiplied by 8 hours per day) and 24 hours of service in the 1978 vesting computation period (3 days multiplied by 8 hours per day).

(iii) Same facts as in Example (ii), above, except that the plan adopts the practice of crediting hours of service for sick leave and other periods of compensated absences to the vesting computation period in which the employer's bi-weekly payroll period ends. The employee returns to work on January 5, 1978 and works for 2 days. For the 2-week payroll period ending on January 8, 1978, the employee may be credited with 80 hours of service in the 1978 vesting computation period (64 hours of service for the paid sick leave and 16 hours of service for the 2 days during which duties were performed).

(d) *Other Federal law*. Nothing in this section shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States or any rule or regulation issued under any such law. Thus, for example, nothing in this section shall be construed as denying an employee credit for an ''hour of service'' if credit is required by separate Federal law. Furthermore, the nature and extent of such credit shall be determined under such law.

(e) *Additional examples*. (1) During a computation period, an employee was paid for working 38¼ hours a week for 45 weeks. During the remaining 7 weeks of the computation period the employee was not employed by this employer. The employee completed 1,721¼ hours of service (45 weeks worked multiplied by 38¼ hours per week). The employer may also round up hours at the end of the computation period or more frequently. Thus, this employee could be credited with 1,722 hours of service (or, if the employer rounded up at the end of each week, 39 hours of service per week, resulting in credit for 1,755 hours of service).

(2) During a computation period, an employee was paid for a workweek of 40 hours per week for 40 weeks and, including overtime, for working 50 hours per week for 8 weeks. The employee completed 2,000 hours of service (40 weeks multiplied by 40 hours per week, plus 8 weeks worked multiplied by 50 hours per week).

(3) During a computation period an employee was paid for working 2 regularly scheduled 40-hour weeks and then became disabled. The employee was disabled through the remainder of the computation period and the following computation period. Throughout the period of disability, payments were made to the employee as follows: For the first month of the period of disability, the employer continued to pay the employee the employee's normal compensation at the same rate as before the disability occurred; thereupon, under the employer's disability insurance policy, payments were made to the employee in amounts equal to 80 percent of the employee's compensation before the disability. For the first computation period the employee is credited with 80 hours of service for the performance of duties (2 weeks multiplied by 40 hours per week) and 501 hours hours of service for the period of disability (the lesser of 501 hours of service or 50 weeks multiplied by 40 hours per week), or a total of 581 hours of service; for the second computation period the employee is credited with no hours of service because, under paragraph (a)(2)(i) of this section, the maximum of 501 hours of service has been credited for the period of disability in the first computation period.

(4) An employee has a regularly scheduled 5-day, 40-hour week. During a computation period the employee works for the first week, spends the second week on a paid vacation, returns to work for an hour and is then disabled for the remainder of the computation period. Payments under a disability plan maintained by the employer are made to the employee on account of the period of disability. The employee is credited with 582 hours of service for the computation period (40 hours for the period of paid vacation; 41 hours for the performance of duties; 501 hours for the period of disability).

(5) Same facts as in Example (4), above, except that the employee's period of disability begins before the employee returns from vacation to the performance of duties. The employee is credited with only 541 hours of service,

because the paid vacation and the disability together constitute a single, continuous period during which no duties were performed and, therefore, under paragraph (a)(2)(i) of this section, no more than 501 hours of service are required to be credited for such period.

(6) During a computation period, an employee worked 40 hours a week for the first 2 weeks. The employee then began serving on active duty in the Armed Forces of the United States, which service occupied the remaining 50 weeks of the computation period. The employee would be credited with 80 hours (2 weeks worked multiplied by 40 hours) plus such credit as may be prescribed by separate Federal laws relating to military service. The nature and extent of the credit that the employee receives upon his return and the purpose for which such credit is given, e.g., the percentage of his or her accrued benefits derived from employer contributions which are nonforfeitable (or vested), will depend upon the interpretation of the Federal law governing veterans' reemployment rights.

(f) *Plan document.* A plan which credits service on the basis of hours of service must state in the plan document the definition of hours of service set forth in paragraph (a) of this section, but is not required to state the rules set forth in paragraph (b) and (c) of this section if they are incorporated by reference.

§ 2530.200b–3 Determination of service to be credited to employees.

(a) *General rule.* For the purpose of determining the hours of service which must be credited to an employee for a computation period, a plan shall determine hours of service from records of hours worked and hours for which payment is made or due or shall use an equivalency permitted under paragraph (d), (e) or (f) of this section to determine hours of service. Any records may be used to determine hours of service to be credited to employees under a plan, even though such records are maintained for other purposes, provided that they accurately reflect the actual number of hours of service with which an employee is required to be credited under § 2530.200b–2(a). Payroll records, for example, may provide sufficiently accurate data to serve as a basis for determining hours of service. If, however, existing records do not accurately reflect the actual number of hours of service with which an employee is entitled to be credited, a plan must either develop and maintain adequate records or use one of the permitted equivalencies. A plan may in any case credit hours of service under any method which results in the crediting of no less than the actual number of hours of service required to be credited under § 2530.200b–2(a) to each employee in a computation period, even though such method may result in the crediting of hours of service in excess of the number of hours required to be credited under § 2530.200b–2. A plan is not required to prescribe in its documents which records are to be used to determine hours of service.

(b) *Determination of pre-effective date hours of service.* To the extent that a plan is required to determine hours of service completed before the effective date of part 2 of title I of the Act (see section 211 of the Act), the plan may use whatever records may be reasonably accessible to it and may make whatever calculations are necessary to determine the approximate number of hours of service completed before such effective date. For example, if a plan or an employer maintaining the plan has, or has access to, only the records of compensation of employees for the period before the effective date, it may derive the pre-effective date hours of service by using the hourly rate for the period or the hours customarily worked. If accessible records are insufficient to make an approximation of the number of pre-effective date hours of service for a particular employee or group of employees, the plan may make a reasonable estimate of the hours of service completed by such employee or employees during the particular period. For example, if records are available with respect to some employees, the plan may estimate the hours of other employees in the same job classification based on these records. A plan may use any of the equivalencies permitted under this section, or the elapsed time method of crediting service permitted under this

section, or the elapsed time method of crediting service permitted under § 2530.200b–9, to determine hours of service completed before the effective date of part 2 of title I of the Act.

(c) *Use of equivalencies for determining service to be credited to employees.* (1) The equivalencies permitted under paragraphs (d), (e) and (f) of this section are methods of determining service to be credited to employees during computation periods which are alternatives to the general rule for determining hours of service set forth in paragraph (a) of this section. The equivalencies are designed to enable a plan to determine the amount of service to be credited to an employee in a computation period on the basis of records which do not accurately reflect the actual number of hours of service required to be credited to the employee under § 2530.200b–2(a). However, the equivalencies may be used even if such records are maintained. Any equivalency used by a plan must be set forth in the document under which the plan is maintained.

(2) A plan may use different methods of crediting service, including equivalencies permitted under paragraphs (d), (e) and (f) of this section and the method of crediting service under the general rule set forth in § 2530.200b–2(a), for different classifications of employees covered under the plan or for different purposes, provided that such classifications are reasonable and are consistently applied. Thus, for example, a plan may provide that part-time employees are credited under the general method of crediting service set forth in § 2530.200b–2 and full-time employees are credited under a permissible equivalency. A classification, however, will not be deemed to be reasonable or consistently applied if such classification is designed with an intent to preclude an employee or employees from attaining statutory entitlement with respect to eligibility to participate, vesting or benefit accrual. For example, a classification applied so that any employee credited with less than 1,000 hours of service during a given 12-consecutive-month period would be considered part-time and subject to the general method of crediting service rather than an equivalency would not be reasonable.

(3) Notwithstanding paragraphs (c)(1) and (2) of this section, the use of a permissible equivalency for some, but not all, purposes or the use of a permissible equivalency for some, but not all, employees may, under certain circumstances, result in discrimination prohibited under section 401a of the Code, even though it is permitted under this section.

(d) *Equivalencies based on working time*—(1) *Hours worked.* A plan may determine service to be credited to an employee on the basis of hours worked, as defined in paragraph (d)(3)(i) of this section, if 870 hours worked are treated as equivalent to 1,000 hours of service and 435 hours worked are treated as equivalent to 500 hours of service.

(2) *Regular time hours.* A plan may determine service to be credited to an employee on the basis of regular time hours, as defined in paragraph (d)(3)(ii) of this section, if 750 regular time hours are treated as equivalent to 1,000 hours of service and 375 regular time hours are treated as equivalent to 500 hours of service.

(3) For purposes of this section:

(i) The term ''hours worked'' shall mean hours of service described in § 2530.200b–2(a)(1), and hours for which back pay, irrespective of mitigation of damages, is awarded or agreed to by an employer, to the extent that such award or agreement is intended to compensate an employee for periods during which the employee would have been engaged in the performance of duties for the employer.

(ii) The term ''regular time hours'' shall mean hours worked, except hours for which a premium rate is paid because such hours are in excess of the maximum workweek applicable to an employee under section 7(a) of the Fair Labor Standards Act of 1938, as amended, or because such hours are in excess of a bona fide standard workweek or workday.

(4) A plan determining service to be credited to an employee on the basis of hours worked or regular time hours shall credit hours worked or regular time hours, as the case may be, to computation periods in accordance with the rules for crediting hours of service

to computation periods set forth in § 2530.200b–2(c).

(5) *Examples*. (i) A defined benefit plan uses the equivalency based on hours worked permitted under paragraph (d)(1) of this section. The plan uses the same 12-consecutive-month period for the vesting and accrual computation periods. The plan credits a participant with each hour for which the participant is paid, or entitled to payment, for the performance of duties for the employer during a computation period (as well as each hour for which back pay is awarded or agreed to). During a vesting/accrual computation period Participant A is credited with 870 hours worked. A is credited with a year of service for purposes of vesting for the computation period and with at least a partial year of participation for purposes of accrual, as if A had been credited with 1000 hours of service during the computation period. During the same computation period Participant B is credited with 436 hours of service. B is not credited with a year of service for purposes of vesting or a partial year or paritcipation for purposes of accrual for the computation period, but does not incur a one-year break in service for the computation period, as if B had been credited with 501 hours of service during the computation period.

(ii) A plan uses the equivalency based on regular time hours permitted under paragraph (d)(2) of this section. During a computation period a participant works 370 regular time hours and 20 overtime hours. The participant incurs a one-year break in service for the computation period because he has not been credited with 375 regular time hours in the computation period.

(e) *Equivalencies based on periods of employment*. (1) Except as provided in paragraphs (e)(4) and (6) of this section, a plan may determine the number of hours of service to be credited to employees in a computation period on the following bases:

(i) On the basis of days of employment, if an employee is credited with 10 hours of service for each day for which the employee would be required to be credited with at least one hour of service under § 2530.200b–2;

(ii) On the basis of weeks of employment, if an employee is credited with 45 hours of service for each week for which the employee would be required to be credited with at least one hour of service under § 2530.200b–2;

(iii) On the basis of semi-monthly payroll periods, if an employee is credited with 95 hours of service for each semi-monthly payroll period for which the employee would be required to be credited with at least one hour of service under § 2530.200b–2; or

(iv) On the basis of months of employment, if an employee is credited with 190 hours of service for each month for which the employee would be required to be credited with at least one hour of service under § 2530.200 b–2.

(2) Except as provided in paragraphs (e)(4) and (6) of this section, a plan may determine the number of hours of service to be credited to employees in a computation period on the basis of shifts if an employee is credited with the number of hours included in a shift for each shift for which the employee would be required to be credited with at least one hour of service under § 2530.200b–2. if a plan uses the equivalency based on shifts permitted under this paragraph, the times of the beginning and end of each shift used as a basis for the determination of service shall be set forth in a document referred to in the plan.

(3) *Examples*. The following examples illustrate the application of paragraphs (e)(1) and (2) of this section;

(i) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee works for one hour on the first workday of a week and then takes leave without pay for the entire remainder of the week. The plan must credit the employee with 45 hours of service for the week.

(ii) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee spends a week on vacation with pay. The plan must credit the employee with 45 hours of service for the week.

(iii) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee spends two days of a week on vacation with pay and the

remainder of the week on leave without pay. The plan must credit the employee with 45 hours of service for the week.

(iv) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee spends the entire week on leave without pay. The plan is not required to credit the employee with any hours of service for the week because no payment was made to the employee for the week of leave and, therefore, under § 2530.200b–2 no hours of service would be credited to the employee for the week of leave.

(v) The workday of an employer maintaining a plan is scheduled in shifts. Ordinarily, each shift is 6 hours in duration. At certain times, however, the employer schedules 8-hour shifts in order to meet increased demand. Such shifts are described in a collective bargaining agreement referred to in the plan documents. The plan must credit an employee with 6 hours of service for each 6-hour shift for which the employee would be credited with one hour of service under § 2530.200b–2, and with 8 hours of service for each such 8-hour shift.

(vi) An employer's workday is divided into three 8-hour shifts, each employee generally working 5 shifts per week. A plan maintained by the employer uses the equivalency based on shifts permitted under paragraph (e)(2) of this section. An employee is on vacation with pay for 2 weeks, during which, in the ordinary course of his work schedule, he would have worked 10 shifts. The employee must be credited with 80 hours of service for the vacation (10 shifts multiplied by 8 hours per shift).

(vii) An employer's workday is divided into three 8-hour shifts, each employee generally working 1 shift per workday. A plan maintained by the employer uses the equivalency based on shifts permitted under paragraph (e)(2) of this section. On a certain day, an employee works his normal 8-hour shift and an hour during the following shift. In addition to 8 hours service for the first shift, the employee must be credited with 8 hours of service for the following shift, since he would be entitled to be credited with at least one hour of service for the second shift under § 2530.200b–2.

(viii) A plan uses the equivalency based on days permitted under paragraph (e)(1)(i) of this section. During a computation period an employee spends 2 weeks on vacation with pay. In the ordinary course of the employee's regular work schedule, the employee would be engaged in the performance of duties for 10 days during the 2-week vacation period. Under § 2530.200b–2, the employee would be credited with at least one hour of service for each of the 10 days during the 2-week vacation for which the employee would ordinarily be engaged in the performance of duties. Under paragraph (e)(4) of this section, the employee is credited with 100 hours of service for the 2-week vacation (10 days multiplied by 10 hours of service per day).

(4) For purposes of this paragraph, in the case of a payment described in § 2530.200b–2(b)(2) (relating to payments not calculated on the basis of units of time), a plan using an equivalency based on units of time permitted under this paragraph shall credit the employee with the number of hours of service determined under paragraph (2) of § 2530.200b–2(b), and, to the extent applicable, paragraph (e)(3), containing the rule against double crediting, of § 2530.200b–2(b). For example, if an employee with a regular work schedule of 40 hours per week paid at a rate of $3.00 per hour is incapacitated for a period of 4 weeks and receives a lump sum payment of $500 for his incapacity, the employee must be credited with 160 hours of service for the period of incapacity, regardless of whether the plan uses an equivalency permitted under this paragraph (*see* example at § 2530.200b–2(b)(2)(iii)(A). If, however, the employee is incapacitated for only 3 weeks, under § 2530.200b–2(b)(3) the emmployee is not required to be credited with more than 120 hours of service (lesser of 167 hours of service determined under the preceding sentence or 3 weeks multiplied by 40 hours per week).

(5) For purposes of this paragraph, in the case of a payment to an employee calculated on the basis of units of time which are greater than the periods of employment used by a plan as a basis

for determining service to be credited to the employee under this paragraph, the plan shall credit the employee with the number of periods of employment which, in the course of the employee's regular work schedule, would be included in the unit or units of time on the basis of which the payment is calculated. For example, a plan uses the equivalency based on days permitted under paragraph (e)(1)(i) of this section. During a computation period an employee spends 2 weeks on vacation with pay. In the ordinary course of the employee's regular work schedule, the employee would be engaged in the performance of duties for 10 days during the 2-week vacation period. Under § 2530.200b–2, the emplopyee would be credited with at least one hour of service for each of the 10 days during the 2-week vacation for which the employee would ordinarily be engaged in the performance of duties. Under this paragraph the employee is credited with 100 hours of service for the 2-week vacation (10 days multiplied by 10 hours of service per day). If, however, the employee, although paid for a 2-week vacation, spends only one week on vacation, under § 2530.200b–2(b)(3) the employee is not required to be credited with more than 50 hours of service (5 days multiplied by 10 hours per day).

(6) For purposes of this paragraph, in the case of periods of time used as a basis for determining service to be credited to an employee which extend into two computation periods, the plan may credit all hours of service (or other units of service) credited for such a period to the first computation period or the second computation period, or may allocate such hours of service (or other units of service) between the two computation periods on a pro rata basis. Crediting of service under this paragraph must be done consistently with respect to all employees within the same job classifications, reasonably defined.

(7) A plan may combine an equivalency based on working time permitted under paragraph (d) of this section (i.e., hours worked or regular time hours) with an equivalency based on periods of employment permitted under this paragraph if the following conditions are met:

(i) The plan credits an employee with the number of hours worked or regular time hours, as the case may be, equal to the number of hours of service which would be credited to the employee under paragraphs (e)(1) and (2) of this section, for each period of employment for which the employee would be credited with one hour worked or one regular time hour; and

(ii) The plan treats hours worked and regular time hours in the manner prescribed under paragraphs (d)(1) and (2) of this section.

(8) *Example.* The following example illustrates the application of paragraph (e)(7) of this section. A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section in conjunction with the equivalency based on hours worked permitted under paragraph (d)(1) of this section, as provided in paragraph (e)(7) of this section. During a vesting computation period an employee is paid for the performance of duties for at least 1 hour in each of the first 20 weeks of the computation period and spends the next 2 weeks on a paid vacation. The employee thereupon terminates employment performing no further duties for the employer, and receiving no further compensation in the computation period. The employee is therefore credited with 900 hours worked for the vesting computation period (20 weeks multiplied by 45 hours per week), receiving no credit for the two weeks of paid vacation. The employee is credited with a year of service for the vesting computation period because he has been credited with more than 870 hours for the computation period.

(f) *Equivalencies based on earnings.* (1) In the case of an employee whose compensation is determined on the basis of an hourly rate, a plan may determine the number of hours to be credited the employee in a computation period on the basis of earnings, if:

(i) The employee is credited with the number of hours equal to the total of the employee's earnings from time to time during the computation period divided by the employee's hourly rate as

in effect at such times during the computation period, or equal to the employee's total earnings for the performance of duties during the computation period divided by the employee's lowest hourly rate of compensation during the computation period, or by the lowest hourly rate of compensation payable to an employee in the same, or a similar job classification, reasonably defined; and

(ii) 870 hours credited under paragraph (f)(1)(i) of this section are treated as equivalent to 1,000 hours of service, and 435 hours credited under paragraph (f)(1)(i) of this section are treated as equivalent to 500 hours of service.

For purposes of this paragraph (f)(1), a plan may divide earnings at premium rates for overtime by the employee's hourly rate for overtime, rather than the regular time hourly rate.

(2) In the case of an employee whose compensation is determined on a basis other than an hourly rate, a plan may determine the number of hours to be credited to the employee in a computation period on the basis of earnings if:

(i) The employee is credited with the number of hours equal to the employee's total earnings for the performance of duties during the computation period divided by the employee's lowest hourly rate of compensation during the computation period, determined under paragraph (f)(3) of this section; and

(ii) 750 hours credited under paragraph (f)(2)(i) of this section are treated as equivalent to 1,000 hours of service, and 375 hours credited under paragraph (f)(2)(i) of this section are treated as equivalent to 500 hours of service.

(3) For purposes of paragraph (f)(2) of this section, an employee's hourly rate of compensation shall be determined as follows:

(i) In the case of an employee whose compensation is determined on the basis of a fixed rate for a specified period of time (other than an hour) such as a day, week or month, the employee's hourly rate of compensation shall be the employee's lowest rate of compensation during a computation period for such specified period of time divided by the number of hours regularly scheduled for the performance of duties during such period of time. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, the plan may provide for the calculation of the employee's hourly rate of compensation on the basis of a 40-hour workweek or an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee over a representative period of time, provided that the basis so used is consistently applied to all employees within the same job classifications, reasonably defined.

(ii) In the case of an employee whose compensation is not determined on the basis of a fixed rate for a specified period of time, the employee's hourly rate of compensation shall be the lowest hourly rate of compensation payable to employees in the same job classification as the employee, or, if no employees in the same job classification have an hourly rate, the minimum wage as established from time to time under section 6(a)(1) of the Fair Labor Standards Act of 1938, as amended.

(4) *Examples*. (i) In a particular job classification employees' wages range from $3.00 per hour to $4.00 per hour. To determine the number of hours to be credited to an employee in that job classification who is compensated at a rate of $4.00 per hour, a plan may divide the employee's total earnings during the computation period for the performance of duties either by $3.00 per hour (the lowest hourly rate of compensation in the job classification) or by $4.00 per hour (the employee's own hourly rate of compensation).

(ii) An hourly employee's total earnings for the performance of duties during a vesting computation period amount to $4,350. During that calendar year, the employee's lowest hourly rate of compensation was $5.00 per hour. The plan may determine the number of hours to be credited to the employee for that vesting computation period by dividing $4,350 by $5.00 per hour. The employee is credited with 870 hours for the vesting computation period and is, therefore, credited with a year of service for purposes of vesting.

(iii) During the first 3 months of a vesting computation period an hourly employee is paid at a rate of $3.00 per

hour and earns $675 for the performance of duties; during the next 6 months, the employee is paid at a rate of $3.50 per hour and earns $1,575 for the performance of duties; during the final 3 months the employee is paid at a rate of $3.60 per hour and earns $810 for the performance of duties. The plan may determine the number of hours to be credited to the employee in the computation period under the equivalency set forth in paragraph (f)(1) of this section either (A) by dividing the employee's earnings for each period during which the employee was paid at a separate rate ($675 divided by $3.00 per hour equals 225 hours; $1,575 divided by $3.50 per hour equals 450 hours; $810 divided by $3.60 per hour equals 225 hours) and adding the hours so obtained (900 hours), or (B) by dividing the employee's total compensation for the vesting computation period by the employee's lowest hourly rate during the computation period ($3,020 divided by $3.00 per hour equals 1,009⅔ hours). The plan may also divide the employee's total compensation during the computation period by the lowest hourly rate payable to an employee in the same, or a similar, job classification.

(iv) During a plan's computation period an hourly employee's total earnings for the performance of duties consist of $7,500 at a basic rate of $5.00 per hour and $750 at an overtime rate of $7.50 per hour for hours worked in excess of 40 in a week. If the plan uses the equivalency permitted under paragraph (f)(1) of this section, the plan may adjust for the overtime rate in calculating the number of hours to be credited to the employee. Thus, the plan may calculate the number of hours to be credited to the employee by adding the employee's earnings at the basic rate divided by the basic rate and the employee's earnings at the overtime rate divided by the overtime rate ($7,500 divided by $5.00 per hour, plus $750 divided by $7.50 per hour, or 1,500 hours plus 100 hours), resulting in credit for 1,600 hours for the computation period.

(v) During a plan's vesting computation period an employee's lowest weekly rate of compensation is $400 per week. The employee has a regular work schedule of 40 hours per week. The employee's lowest hourly rate during the vesting computation period is, therefore, $10 per hour ($400 per week divided by 40 hours per week). During the vesting computation period, the employee receives a total of $7,500 for the performance of duties. The plan determines the number of regular time hours to be credited to the employee for the computation period by dividing $7,500 by $10 per hour. The employee is credited with 750 hours for the computation period and is, therefore, credited with a year of service for purposes of vesting.

§ 2530.200b–4 One-year break in service.

(a) *Computation period.* (1) Under sections 202(b) and 203(b)(3) of the Act and sections 410(a)(5) and 411(a)(6) of the Code, a plan may provide that an employee incurs a one-year break in service for a computation period or periods if the employee fails to complete more than 500 hours of service or, in the case of any maritime industry, 62 days of service in such period or periods.

(2) For purposes of section 202(b) of the Act and section 410(a)(5) of the Code, relating to one-year breaks in service for eligibility to participate, in determining whether an employee incurs a one-year break in service, a plan shall use the eligibility computation period designated under § 2530.202–2(b) for measuring years of service after the intital eligibility computation period.

(3) For purposes of section 203(b)(3) of the Act and section 411(a)(6) of the Code, relating to breaks in service for purposes of vesting, in determining whether an employee incurs a one-year break in service, a plan shall use the vesting computation period designated under § 2530.203–2(a).

(4) For rules regarding service which is not required to be taken into account for purposes of benefit accrual, see § 2530.204–1(b)(1).

(b) *Service following a break in service.* (1) For purposes of section 202(b)(3) of the Act and section 410(a)(5)(C) of the Code (relating to completion of a year of service for eligibility to participate after a one-year break in service), the following rules shall be applied in measuring completion of a year of

service upon an employee's return after a one-year break in service:

(i) In the case of a plan which, after the initial eligibility computation period, measures years of service for purposes of eligibility to participate on the basis of eligibility computation periods beginning on anniversaries of an employee's employment commencement date, as permitted under § 2530.202–2(b)(1), the plan shall use the 12-consecutive-month period beginning on an employee's reemployment commencement date (as defined in paragraphs (b)(1)(iii) and (iv) of this section) and, where necessary, subsequent 12-consecutive-month periods beginning on anniversaries of the reemployment of commencement date.

(ii) In the case of a plan which, after the initial eligibility computation period, measures years of service for eligibility to participate on the basis of plan years beginning with the plan year which includes the first anniversary of the initial eligibility computation period, as permitted under § 2530.202–2(b)(2), the plan shall use the 12-consecutive-month period beginning on an employee's reemployment commencement date (as defined in paragraphs (b)(1)(iii) and (iv) of this section and, where necessary, plan years beginning with the plan year which includes the first anniversary of the employee's reemployment commencement date.

(iii) Except as provided in paragraph (b)(1)(iv) of this section, an employee's reemployment commencement date shall be the first day on which the employee is entitled to be credited with an hour of service described in § 2530.200b–2(a)(1) after the first eligibility computation period in which the employee incurs a one-year break in service following an eligibility computation period in which the employee is credited with more than 500 hours of service.

(iv) In the case of an employee who is credited with no hours of service in an eligibility computation period beginning after the employee's reemployment commencement date established under paragraph (b)(1)(iii) of this section, the employee shall be treated as having a new reemployment commencement date as of the first day on which the employee is entitled to be credited with an hour of service described in § 2530.200b–2(a)(1) after such eligibility computation period.

(2) For purposes of section 203(b)(3)(B) of the Act and section 411(a)(6)(B) of the Code (relating to the completion of a year of service for vesting following a one-year break in service), in measuring completion of a year of service upon an employee's return after a one-year break in service, a plan shall use the vesting computation period designated under § 2530.203–2. In the case of a plan which designates a separate vesting computation period for each employee (rather than one vesting computation period for all employees), when an employee who has incurred a one-year break in service later completes an initial hour of service, the plan may change the employee's vesting computation period to a 12-consecutive-month period beginning on the day on which such initial hour of service is completed, provided that the plan follows the rules for changing the vesting computation period set forth in § 2530.203–2(c)(1). Specifically, such a plan must ensure that as a result of the change of the vesting computation period of an employee who has incurred a one-year break in service to the 12-month period beginning on the first day on which the employee later completes an initial hour of service, the employee's vested percentage of the accrued benefit derived from employer contributions will not be less on any date after the change than such nonforfeitable percentage would be in the absence of the change. As under § 2530.203–2(c)(1), the plan will be deemed to satisfy the requirement of that paragraph if, in the case of an employee who has incurred a one-year break in service, the vesting computation period beginning on the day on which the employee completes an hour of service after the one-year break in service begins before the end of the last vesting computation period established before the change of vesting computation periods and, if the employee is credited with 1000 hours of service in both such vesting computation periods, the employee is credited with 2 years of service for purposes of vesting.

(3) For purposes of section 203(b)(3)(B) of the Act and section 411(a)(6)(B) of

the Code (relating to the completion of a year of service for vesting following a one-year break in service), in measuring completion of a year of service upon an employee's return after a one-year break in service, a plan shall use the vesting computation period designated under § 2530.203–2. In the case of a plan which designates a separate vesting computation period for each employee (rather than one vesting computation period for all employees), when an employee who has incurred a one-year break in service later completes an initial hour of service, the plan may change the employee's vesting computation period to a 12-consecutive-month period beginning on the day on which such initial hour of service is completed, provided that the plan follows the rules for changing the vesting computation period set forth in § 2530.203–2(c)(1).

(4) *Examples*. (i) Employer X maintains a pension plan. The plan uses a calendar year vesting computation period and plan year. As conditions for participation, the plan requires that an employee of X complete one year of service and attain age 25, and, in accordance with § 2530.202–2(b)(2), provides that after the initial eligibility computation period, plan years will be used as eligibility computation periods, beginning with the plan year which includes the first anniversary of an employee's employment commencement date. Thus, under paragraph (a)(2) of this section, the plan must use plan years in measuring one-year breaks in service for eligibility to participate. The plan provides that an employee acquires a nonforfeitable right to 100 percent of the accrued benefit derived from employer contributions upon completion of 10 years of service. Under the plan, for purposes of vesting, years of service completed before an employee attains age 22 are not taken into account. The plan also provides that if an employee has incurred a one-year break in service, in computing the employee's period of service for eligibility to participate, years of service before such break will not be taken into account until the employee has completed a year of service with X after the employee's return. The plan further provides that in the case of an employee who has no vested right to an accrued benefit derived from employer contributions, years of service for purposes of eligibility to participate or vesting before a one-year break in service for eligibility or vesting (as the case may be) shall not be required to be taken into account if the number of consecutive one-year breaks in service equals or exceeds the aggregate number of such years of service before such consecutive one-year breaks in service.

(A) Employee A commences employment with X on January 1, 1976 at age 30 and completes a year of service for eligibility to participate and vesting in both the 1976 and 1977 computation periods. A becomes a participant in the plan on January 1, 1977. A terminates employment with X on November 3, 1977, after completing 1,000 hours of service; completes no hours of service in 1978, incurring a one-year break in service; and is reemployed by X on June 1, 1979. A completes 800 hours of service during the remainder of 1979 and 600 hours of service from January 1, 1980 through May 31, 1980. Under paragraph (b)(1)(iii) of this section, A's reemployment commencement date is June 1, 1979. By June 1, 1980, A has completed a year of service during the eligibility computation period following his return, and receives credit for his pre-break service to the extent required under section 202 of the Act and section 410 of the Code and the regulations thereunder. The plan is not, however, required to credit A with a year of service for vesting during 1979 because he failed to complete 1,000 hours of service during that vesting computation period. If A completes 400 or more hours of service from June 1, 1980 to December 31, 1980, then A will be credited with one year of service for vesting purposes for the 1980 vesting computation period.

(B) Employee B was born on February 22, 1955 and commenced employment with Employer X on July 1, 1975. B is credited with a year of service for eligibility to participate in the plan for the eligibility computation period beginning on his employment commencement date (July 1, 1975) and a year of service for eligibility and vesting for the 1976 and 1977 plan years. As of the end of the 1977 plan year, B is credited

with 3 years of service for purposes of eligibility to participate, but only one year of service for purposes of vesting. Not having attained age 25, however, B is not admitted to participation in the plan upon completion of his first year of service with X. In the 1978 plan year, B fails to be credited with 500 hours of service, thereby incurring a one-year break in service. As a result of B's one-year break in service in the 1978 plan year, the year of service for vesting which was earlier credited to B for the 1977 plan year is disregarded because the one-year break in service equals the one year of service credited to B before the one-year break in service. After the end of the 1978 plan year, B does not perform an hour of service with X until February 3, 1979. February 3, 1979, therefore, is B's reemployment commencement date under paragraph (b)(1)(i) of this section. B fails to be credited with 1,000 hours of service in the first eligibility computation period beginning on February 3, 1979, and also for the vesting computation period beginning January 1, 1979. Because, in accordance with § 2530.202–2(b)(2), the plan provides that after the initial eligibility computation period, plan years will be used as eligibility computation periods, under paragraph (b)(1)(ii) of this section the plan must provide that, in measuring completion of a year of service for eligibility to participate after a one-year break in service, plan years beginning with the plan year which includes an employee's reemployment commencement date will be used. B is credited with 1,000 hours of service for the plan year beginning on January 1, 1980 and is therefore credited with a year of service for the 1980 plan year. Under section 202(b)(3) of the Act and section 410(a)(5)(C) of the Code, as a consequence of B's completion of a year of service in the 1980 plan year, B's service before his one-year break in service in the 1978 plan year must be taken into account for eligibility purposes. As conditions of participation, the plan requires that an employee attain age 25 and complete one year of service. Upon his completion of a year of service for the 1980 plan year, B is deemed to have met the plan's participation requirements as of February 22, 1980, his twenty-fifth birthday, because the year of service completed by B in B's eligibility computation period beginning on January 1, 1976 is taken into account for eligibility purposes.

(ii) Employer Y maintains a defined benefit pension plan. The plan provides that an employee acquires a nonforfeitable right to 100 percent of the employee's accrued benefit derived from employer contributions upon completion of 10 years of service. As conditions for participation, the plan requires that an employee of Y complete one year of service and provides that if an employee has incurred a one-year break in service, in computing the employee's period of service for eligibility to participate, years of service before such break will not be taken into account until the employee has completed a year of service with Y after the employee's return. In accordance with § 2530.202–2(b)(1), the plan provides that after the initial eligibility computation period, eligibility computation periods beginning on anniversaries of an employee's employment commencement date will be used. Thus, under paragraph (a)(1) of this section, the plan must use computation periods beginning on anniversaries of the employee's employment commencement date in measuring one-year breaks in service. Employee C's employment commencement date with Y is February 1, 1975, C is credited with a year of service for eligibility to participate in the eligibility computation period beginning on C's employment commencement date and meets the plan's eligibility requirements as of February 1, 1976. In accordance with the provisions of the plan, C commences participation in the plan as of July 1, 1976. C is thereafter credited with a year of service for eligibility to participate in each of the eligibility computation periods beginning on anniversaries of C's employment commencement date (February 1) in 1976, 1977, 1978 and 1979. Thus, as of February 1, 1980, C is credited with 5 years of service for eligibility to participate. In the eligibility computation period beginning on February 1, 1980, C fails to be credited with more than 500 hours of service and therefore incurs a one-year break in service. In the eligibility computation

period beginning on February 1, 1981, C is not credited with an hour of service for the performance of duties until March 1, 1981. Under paragraph (b)(1)(iii) of this section, March 1, 1981 is C's reemployment commencement date. C terminates employment with Y on May 1, 1981 and fails to be credited with 1000 hours of service in the 12-consecutive-month period beginning on March 1, 1981, or with more than 500 hours of service in the eligibility computation period beginning on February 1, 1981, thereby incurring a second one-year break in service for eligibility to participate. C is credited with no hours of service in the eligibility computation period beginning on February 1, 1982, thereby incurring a third one-year break in service for eligibility to participate, and is likewise credited with no hours of service in the 12-consecutive-month period beginning on March 1, 1982, the anniversary of B's reemployment commencement date. Under paragraph (b)(1)(iv) of this section, C must therefore be treated as having a new reemployment commencement date as of the first day following the close of the eligibility computation period beginning on February 1, 1982. On January 1, 1984 (before the end of the eligibility computation period beginning February 1, 1983) C is rehired by Y and is credited with an hour of service for the performance of duties. C is therefore treated as having a new reemployment commencement date January 1, 1984. C fails to be credited with more than 500 hours of service in the eligibility computation period beginning on February 1, 1983, thereby incurring a fourth one-year break in service, and fails to be credited with 1000 hours of service in the 12-consecutive-month period beginning on March 1, 1983, the anniversary of C's original reemployment commencement date. However, in the 12-consecutive-month period beginning on January 1, 1984, C is credited with 1000 hours of service, thus meeting the plan's requirement that an employee who has incurred a one-year break in service for eligibility to participate must complete a year of service upon the employee's return in order for years of service before the one-year break in service to be taken into account for purposes of eligibility. Because C's years of service completed before C's first one-year break in service must be taken into account under section 202(b) of the Act and section 410(b)(5) of the Code for purposes of eligibility to participate, under § 2530.204–2(a)(2) the period beginning on July 1, 1976 (the earliest date on which C was a participant) and extending until January 31, 1980 (the last day before C's first one-year break in service) must be taken into account for purposes of benefit accrual.

(c) *Prior service for eligibility to participate.* For rules relating to computing service preceding a break in service for the purpose of eligibility to participate in the plan, see § 2530.202–2(c).

(d) *Prior service for vesting.* For rules relating to computing service preceding a break in service for the purpose of credit toward vesting, see § 2530.203–2(d).

§ 2530.200b–5 Seasonal industries. [Reserved]

§ 2530.200b–6 Maritime industry.

(a) *General.* Sections 202(a)(3)(D), 203(b)(2)(D) and 204(b)(3)(E) of the Act and sections 410(a)(3)(D) and 411(a)(5)(D) and (b)(3)(E) of the Code contain special provisions applicable to the maritime industry. In general, those provisions permit statutory standards otherwise expressed in terms of 1,000 hours of service to be applied to employees in the maritime industry as if such standards were expressed in terms of 125 days of service. A plan covering employees in the maritime industry may nevertheless credit service to such employees on the basis of hours of service, as prescribed in § 2530.200b–2, including the use of any equivalency permitted under § 2530.200b–3, or may credit service to such employees on the basis of elapsed time, as permitted under § 2530.200b–9.

(b) *Definition.* For purposes of sections 202, 203, and 204 of the Act and sections 410 and 411 of the Code, the maritime industry is that industry in which employees perform duties on board commercial, exploratory, service or other vessels moving on the high seas, inland waterways, Great Lakes,

coastal zones, harbors and noncontiguous areas, or on offshore ports, platforms or other similar sites.

(c) *Computation periods.* For employees in the maritime industry, computation periods shall be established as for employees in any other industry.

(d) *Year of service.* To the extent that a plan covers employees engaged in the maritime industry, and credits service for such employees on the basis of days of service, such employees who are credited with 125 days of service in the applicable computation period must be credited with a year of service. In the case of a plan covering both employees engaged in the maritime industry and employees not engaged in the maritime industry, service of employees not engaged in the maritime industry shall not be determined on the basis of days of service.

(e) *Year of participation for benefit accrual.* A plan covering employees engaged in the maritime industry may determine such an employee's period of service for purposes of benefit accrual on any basis permitted under §§ 2530.204–2 and 2530.204–3. For purposes of § 2530.204–2(c) (relating to partial years of participation), in the case of an employee engaged in the maritime industry who is credited by the plan on the basis of days of service and whose service is not less than 125 days of service during an accrual computation period, the calculation of such employee's period of service for purposes of benefit accrual shall be treated as not made on a reasonable and consistent basis if service during such computation period is not taken into account. Thus, the employee must be credited with at least a partial year of participation (but not necessarily a full year of participation) for that accrual computation period, in accordance with § 2530.204–2(c).

(f) *Employment commencement date.* For purposes of § 2530.200b–4 (relating to breaks in service) and § 2530.202–2 (relating to eligibility computation periods):

(1) The employment commencement date of an employee engaged in the maritime industry who is credited by the plan on the basis of days of service shall be the first day for which the employee is entitled to be credited with a day of service described in § 2530.200b–7(a)(1).

(2)(i) Except as provided in paragraph (f)(2)(ii) of this section, the reemployment commencement date of an employee engaged in the maritime industry shall be the first day for which the employee is entitled to be credited with a day of service described in § 2530.200b–7(a)(1) after the first eligibility computation period in which the employee incurs a 1-year break in service following an eligibility computation period in which the employee is credited with more than 62 days of service.

(ii) In the case of an employee engaged in the maritime industry who is credited with no hours of service in an eligibility computation period beginning after the employee's reemployment commencement date established under paragraph (f)(2)(i) of this section, the employee shall be treated as having a new reemployment commencement date as of the first day for which the employee is entitled to be credited with day of service described in § 2530.200b–7(a)(1) after such eligibility computation period.

§ 2530.200b–7 Day of service for employees in the maritime industry.

(a) *General rule.* A day of service in the maritime industry which must, as a minimum, be counted for the purposes of determining a year of service, a year of participation for benefit accrual, a break in service and an employment commencement date (or reemployment commencement date) under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code by a plan that credits service by days of service rather than hours of service (as prescribed in § 2530.200b–2, or under equivalencies permitted under § 2530.200b–3) or elapsed time (as permitted under § 2530.200b–9), is a day of service as defined in paragraphs (a)(1), (2) and (3) of this section.

(1) A day of service is each day for which an employee is paid or entitled to payment for the performance of duties for the employer during the applicable computation period.

(2) A day of service is each day for which an employee is paid, or entitled

to payment, by the employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Notwithstanding the preceding sentence:

(i) No more than 63 days of service are required to be credited under this paragraph (a)(2) to an employee on account of any single continuous period during which the employee performs no duties (whether or not such period occurs in a single computation period);

(ii) A day for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed is not required to be credited to the employee if such payment is made or due under a plan maintained solely for the purpose of complying with applicable workmen's compensation (including maintenance and care), or unemployment compensation or disability insurance laws; and

(iii) Days of service are not required to be credited for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

For purposes of this paragraph (a)(2), a payment shall be deemed to be made by or due from an employer regardless of whether such payment is made by or due from the employer directly, or indirectly through, among others, a trust, fund, or insurer, to which the employer contributes or pays premiums, and regardless of whether contributions made or due to the trust, fund, insurer or other entity are for the benefit of particular employees or are made on behalf of a group of employees in the aggregate.

(3) A day of service is each day for which back pay, irrespective of mitigation of damages, has been either awarded or agreed to by the employer. Days of service shall not be credited both under paragraph (a)(1) or paragraph (a)(2), as the case may be, and under this subparagraph. Thus, for example, an employee who receives a back pay award following a determination that he or she was paid at an unlawful rate for days of service previously credited will not be entitled to additional credit for the same days of service. Crediting of days of service for back pay awarded or agreed to with respect to periods described in paragraph (a)(2) shall be subject to the limitations set forth in that paragraph. For example, no more than 63 days of service are required to be credited for payments of back pay, to the extent that such back pay is agreed to or awarded for a period of time during which an employee did not or would not have performed duties.

(b) *Special rule for determining days of service for reasons other than the performance of duties.* In the case of a payment which is made or due on account of a period during which an employee performs no duties, and which results in the crediting of days of service under paragraph (a)(3) of this section, or, in the case of an award or agreement for back pay, to the extent that such award or agreement is made with respect to a period described in paragraph (a)(2) of this section, the number of days of service to be credited shall be determined as follows:

(1) *Payments calculated on the basis of units of time.* In the case of a payment made or due which is calculated on the basis of units of time, such as days, weeks or months, the number of days of service to be credited shall be the number of regularly scheduled working days included in the units of time on the basis of which the payment is calculated. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of days of service to be credited on the basis of a 5-day workweek, or may provide for such calculation on any reasonable basis which reflects the average days worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(2) *Payments not calculated on the basis of units of time.* Except as provided in paragraph (b)(3) of this section, in the case of a payment made or due, which is not calculated on the basis of units of time, the number of days of service

to be credited shall be equal to the amount of the payment divided by the employee's most recent daily rate of compensation before the period during which no duties are performed.

(3) *Rule against double credit.* Notwithstanding paragraphs (b)(1) and (2) of this section, an employee is not required to be credited on account of a period during which no duties are performed with a number of days of service which is greater than the number of days regularly scheduled for the performance of duties during such period. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of days of service to be credited to the employee for a period during which no duties are performed on the basis of a 5-day workweek, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees in the same job classifications, reasonably defined.

(c) *Crediting of days of service to computation periods.* (1) Except as provided in paragraph (c)(4) of this section, days of service described in paragraph (a)(1) of this section shall be credited to the computation period in which the duties are performed.

(2) Except as provided in paragraph (c)(4) of this section, days of service described in paragraph (a)(2) of this section shall be credited as follows:

(i) Days of service credited to an employee on account of a payment which is calculated on the basis of units of time, such as days, weeks or months, shall be credited to the computation period or computation periods in which the period during which no duties are performed occurs, beginning with the first unit of time to which the payment relates.

(ii) Days of service credited to an employee by reason of a payment which is not calculated on the basis of units of time shall be credited to the computation period in which the period during which no duties are performed occurs, or if the period during which no duties are performed extends beyond one computation period, such hours of service shall be allocated between not more than the first two computation periods on any reasonable basis which is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(3) Except as provided in paragraph (c)(4) of this section, days of service described in paragraph (a)(3) of this section shall be credited to the computation period or periods to which the award or agreement for back pay pertains, rather than to the computation period in which the award, agreement or payment is made.

(4) In the case of days of service to be credited to an employee in connection with a period of no more than 31 days which extends beyond one computation period, all such days of service may be credited to the first computation period or the second computation period. Crediting of days of service under this paragraph must be done consistently with respect to all employees with the same job classifications, reasonably defined.

(d) *Other federal law.* Nothing in this section shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States or any rule or regulation issued under any such law. Thus, for example, nothing in this section shall be construed as denying an employee credit for a day of service if credit is required by separate federal law. Furthermore, the nature and extent of such credit shall be determined under such law.

(e) *Nondaily employees.* For maritime employees whose compensation is not determined on the basis of certain amounts for each day worked during a given period, service shall be credited on the basis of hours of service as determined in accordance with § 2530.200b–2(a) (including use of any equivalency permitted under § 2530.200b–3) or on the basis of elapsed time, as permitted under § 2530.200b–9.

(f) *Plan document.* A plan which credits service on the basis of days of service must state in the plan document the definition of days of service set forth in paragraph (a) of this section, but is not required to state the rules

set forth in paragraphs (b) and (c) if they are incorporated by reference.

§ 2530.200b–8 Determination of days of service to be credited to maritime employees.

(a) *General rule.* For the purpose of determining the days of service which must be credited to an employee for a computation period, a plan shall determine days of service from records of days worked and days for which payment is made or due. Any records may be used to determine days of service to be credited to employees under a plan, even though such records are maintained for other purposes, provided that they accurately reflect the actual number of days of service with which an employee is required to be credited under § 2530.200b–7(a). Payroll records, for example, may provide sufficiently accurate data to serve as a basis for determining days of service. If, however, existing records do not accurately reflect the actual number of days of service with which an employee is entitled to be credited, a plan must develop and maintain adequate records. A plan may in any case credit days of service under any method which results in the crediting of no less than the actual number of days of service required to be credited under § 2530.200b–7(a) to each employee in a computation period, even though such method may result in the crediting of days of service in excess of the number of days required to be credited under § 2530.200b–7(a). A plan is not required to prescribe in its documents which records are to be used to determine days of service.

(b) *Determination of pre-effective date days of service.* To the extent that a plan is required to determine days of service completed before the effective date of part 2 of title I of the Act (*see* section 211 of the Act), the plan may use whatever records may be reasonably accessible to it and may make whatever calculations are necessary to determine the approximate number of hours of service completed before such effective date. For example, if a plan or an employer maintaining the plan has, or has access to, only the records of compensation of employees for the period before the effective date, it may derive the pre-effective date days of service by using the daily rate for the period or the days customarily worked. If accessible records are insufficient to make an approximation of the number of pre-effective date days of service for a particular employee or group of employees, the plan may make a reasonable estimate of the days of service completed by such employee or employees during the particular period. For example, if records are available with respect to some employees, the plan may estimate the days of service of other employees in the same job classification based on these records. A plan may use the elapsed time method prescribed under § 2530.200b–9 to determine days of service completed before the effective date of part 2 of title I of the Act.

§ 2530.201–1 Coverage; general.

Coverage of the provisions of part 2 of title I of the Act is determined under a multiple step process. First, the plan must be an employee benefit plan as defined under section 3(3) of the Act and § 2510.3–3. (See also the definitions of employee welfare benefit plan, section 3(1) of the Act and § 2510.3–1 and employe pension benefit plan, section 3(2) of the Act and § 2510.3–2). Second, the employee benefit plan must be subject to title I of the Act. Coverage for title I is specified in section 4 of the Act. Third, section 201 of the Act specifies the employee benefit plans subject to title I which are not subject to the minimum standards of part 2 of title I of the Act. Section 2530.201–2 specifies the employee benefit plans subject to title I of the Act which are exempted from coverage under part 2 of title I of the Act and this part (2530).

§ 2530.201–2 Plans covered by part 2530.

This part (2530) shall apply to any employee benefit plan described in section 4(a) of the Act (and not exempted under section 4(b)) other than—

(a) An employee welfare benefit plan as defined in section 3(1) of the Act and § 2510.3–1;

(b) A plan which is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of

management or highly compensated employees;

(c) A plan established and maintained by a society, order, or association described in section 501(c)(8) or (9) of the Code, if no part of the contributions to or under such plan are made by employers of participants in such plan;

(d) A trust described in section 501(c)(18) of the Code;

(e) A plan which is established and maintained by a labor organization described in section 501(c)(5) of the Code and which does not at any time after the date of enactment of the Act provide for employer contributions;

(f) Any agreement providing payments to a retired partner or a deceased partner's successor in interest, as described in section 736 of the Code;

(g) An individual retirement account or annuity described in section 408 of the Code, or a retirement bond described in section 409 of the Code;

(h) An excess benefit plan as described in section 3(36) of the Act.

Subpart B—Participation, Vesting and Benefit Accrual

§ 2530.202–1 Eligibility to participate; general.

(a) Section 202 of the Act and section 410 of the Code contain minimum participation standards relating to certain employee pension benefit plans. In general, an employee pension benefit plan may not require, as a condition of participation in the plan, that an employee complete a period of service with the employer or employers maintaining the plan in excess of limits established by section 202 of the Act and section 410 of the Code and the regulations issued thereunder. Service for this purpose is measured in units of years of service. Section 2530.202–2 sets forth rules relating to the computation periods which a plan must use to determine whether an employee has completed a year of service for purposes of eligibility to participate (''eligibility computation periods'').

(b) For rules relating to ''service with the employer or employers maintaining the plan'', see § 2530.210.

§ 2530.202–2 Eligibility computation period.

(a) *Initial eligibility computation period.* For purposes of section 202(a)(1)(A)(ii) of the Act and section 410(a)(1)(A)(ii) of the Code, the initial eligibility computation period the plan must use is the 12-consecutive-month period beginning on the employment commencement date. An employee's employment commencement date is the first day for which the employee is entitled to be credited with an hour of service described in § 2530.200b–2(a)(1) for an employer maintaining the plan. (For establishment of a reemployment commencement date following a break in service, see § 2530.200b–4(b)(1)(iii) and (iv).)

(b) *Eligibility computation periods after the initial eligibility computation period.* In measuring years of service for purposes of eligibility to participate after the initial eligibility computation period, a plan may adopt either of the following alternatives:

(1) A plan may designate 12-consecutive-month periods beginning on the first anniversary of an employee's employment commencement date and succeeding anniversaries thereof as the eligibility computation period after the initial eligibility computation period; or

(2) A plan may designate plan years beginning with the plan year which includes the first anniversary of an employee's employment commencement date as the eligibility computation period after the initial eligibility computation period (without regard to whether the employee is entitled to be credited with 1,000 hours of service during such period), provided that an employee who is credited with 1,000 hours of service in both the initial eligibility computation period and the plan year which includes the first anniversary of the employee's employment commencement date is credited with two years of service for purposes of eligibility to participate.

(c) *Service prior to a break in service.* For purposes of applying section 202(b)(4) of the Act and section 410(a)(5)(D) of the Code (relating to years of service completed prior to a break in service for purposes of eligibility to participate), the computation

periods used by a plan in determining years of service before such break shall be the eligibility computation periods established in accordance with paragraphs (a) and (b) of this section.

(d) *Plans with 3-year 100 percent vesting.* A plan which, under 202(a)(1)(B)(i) of the Act and section 410a(1)(B)(i) of the Code, requires more than one year of service for eligibility to participate in the plan shall use an initial eligibility computation period established under paragraph (a) of this section and eligibility computation periods designated in accordance with paragraph (b) of this section. Thus, for the eligibility computation period after the initial eligibility computation period, such a plan may designate either eligibility computation periods beginning on anniversaries of an employee's employment commencement date or plan years beginning with the plan year which includes the anniversary of the first day of the initial eligibility computation period.

(e) *Alternative eligibility computation period.* The following rule is designed primarily for a plan using a recordkeeping system which does not permit the plan to identify an employee's employment commencement date (or, in the case of an employee who has incurred a one-year break in service, the employee's reemployment commencement date), but which does permit the plan to identify a period of no more than 31 days during which the employee's employment commencement date (or reemployment commencement date) occurred.

(1) A plan may use an initial eligibility computation period (or initial computation period for measuring completion of a year of service upon an employee's return after a one-year break in service) beginning on the first day of a period of no more than 31 days during which an employee's employment commencement date (or reemployment commencement date) occurs and ending on the anniversary of the last day of such period.

(2) If a plan uses an initial eligibility computation period (or initial computation period for measuring completion of a year of service upon an employee's return after a one-year break in service) permitted under paragraph (e)(1) of this section, the plan shall use the following computation periods after the initial computation period:

(i) If the plan does not use plan years for computation periods after the initial computation period, the plan shall use computation periods beginning on anniversaries of the first day of the initial computation period and ending on anniversaries of the last day of the initial computation period, and including a period of at least 12 consecutive months.

(ii) If the plan uses plan years for computation periods after the initial computation period, the plan shall use plan years beginning with the plan year which includes the anniversary of the first day of the initial computation period.

(3) For purposes of determining an employee's commencement of participation under section 202(a)(4) of the Act and section 410(a)(4) of the Code, regardless of whether an eligibility computation period permitted under this paragraph includes a period longer than 12 consecutive months, an employee who completes 1,000 hours of service in such eligibility computation period shall be treated as having satisfied the plan's service requirement for eligibility to participate as of the last day of the 12-consecutive-month period beginning on the first day of such eligibility computation period. In the case of a plan described in section 202(a)(1)(B)(i) of the Act and section 410(a)(1)(B)(i) of the Code, the requirement of the preceding sentence shall apply only with respect to the last year of service required under the plan for eligibility to participate.

(4) *Example.* A plan maintained by Employer X obtains records from X which indicate the number of hours worked by an employee during a monthly payroll period. The records do not, however, break down the number of hours worked by an employee by days. Thus, after a new employee has begun employment with X it is impossible for the plan to ascertain the employee's employment commencement date from the records furnished by X (although it is possible for the plan to determine the month during which an

employee's employment commencement date occurred). For administrative convenience, in conjunction with the equivalency based on hours worked permitted under § 2530.200b–3(d)(1), and with the method of crediting hours of service to computation periods set forth in § 2530.200b–2(c)(4), the plan uses the alternative initial eligibility computation period permitted under this paragraph. The plan provides that an employee's initial eligibility computation period shall be the period beginning on the first day of the first monthly payroll period for which the employee is entitled to credit for the performance of duties and ending on the last day of the monthly payroll period which includes the anniversary of the last day of the initial monthly payroll period. This condition ensures that the initial eligibility computation period will include the 12-consecutive-month period beginning on the employee's employment commencement date and ending on the day before the anniversary of the employee's employment commencement date. If, however, an employee completes the plans requirement of one year of service for eligibility to participate (i.e., completion of 870 hours worked in an eligibility computation period) in the initial eligibility computation period, the plan provides that the employee is deemed to have satisfied the plan's service requirements for eligibility to participate as of the day before the anniversary of the first day of the initial eligibility computation period. This provision ensures that no employee who has in fact completed 1000 hours of service in the 12-consecutive-month period beginning on the employee's employment commencement date will be admitted to participation later than the date specified under section 202(a)(4) of the Act and section 410(a)(4) of the Code. For example, in the case of an employee who begins employment in January 1977, the employee's initial eligibility computation period begins on January 1, 1977 and ends on January 31, 1978. If the employee completes 879 hours worked in the initial eligibility computation period, the employee is treated as having met the plan's service requirements for eligibility to participate as of December 31, 1977. If the plan provides for semi-annual entry dates of January 1 and July 1, and the employee has met any eligibility requirements of the plan other than the minimum service requirement as of December 31, 1977, the plan must provide that the employee commences participation as of January 1, 1978.

§ 2530.203–1 Vesting; general.

(a) Section 203 of the Act and section 411(a) of the Code contain minimum vesting standards relating to certain employee pension benefit plans. In general, a pension plan subject to section 203 of the Act of section 411(a) of the Code must meet certain requirements relating to an employee's nonforfeitable (''vested'') right to his or her normal retirement benefit. One of these requirements specifies that an employee's accrued benefit derived from employer contributions must be vested in accordance with certain schedules. The schedules (or alternative minimum vesting standards) are generally based on the employee's number of years of service with the employer or employers maintaining the plan. Section 2530.203–2 sets forth rules relating to the computation periods used to determine whether an employee has completed a year of service for vesting purposes (''vesting computation periods'').

(b) For rules relating to service with the employer or employers maintaining the plan, *see* § 2530.210.

§ 2530.203–2 Vesting computation period.

(a) *Designation of vesting computation periods.* Except as provided in paragraph (b) of this section, a plan may designate any 12-consecutive-month period as the vesting computation period. The period so designated must apply equally to all participants. This requirement may be satisfied even though the actual 12-consecutive-month periods are not the same for all employees (e.g., if the designated vesting computation period is the 12-consecutive-month period beginning on an employee's employment commencement date and anniversaries of that date). The plan is prohibited, however, from using any period that would result in artificial postponement of vesting credit, such as a period meassured

by anniversaries of the date four months following the employment commencement date.

(b) *Plans with 3-year 100 percent vesting*. For rules regarding when a participant has a nonforfeitable right to his accrued benefit, see section 202(a)(1)(B)(i) of the Act and section 410(a)(1)(B)(i) of the Code and regulations issued thereunder.

(c) *Amendments to change the vesting computation period*. (1) A plan may be amended to change the vesting computation period to a different 12-consecutive-month period provided that as a result of such change no employee's vested percentage of the accrued benefit derived from employer contributions is less on any date after such change than such vested percentage would be in the absence of such change. A plan amendment changing the vesting computation period shall be deemed to comply with the requirements of this subparagraph if the first vesting computation period established under such amendment begins before the last day of the preceding vesting computation period and an employee who is credited with 1,000 hours of service in both the vesting computation period under the plan before the amendment and the first vesting computation period under the plan as amended is credited with 2 years of service for those vesting computation periods. For example, a plan which has been using a calendar year vesting computation period is amended to provide for a July 1–June 30 vesting computation period starting in 1977. Employees who complete more than 1,000 hours of service in both of the 12-month periods extending from January 1, 1977 to December 31, 1977 and from July 1, 1977 to June 30, 1978 are advanced two years on the plan's vesting schedule. The plan is deemed to meet the requirements of this subparagraph.

(2) For additional requirements pertaining to changes in the vesting schedule, see section 203(c)(1) of the Act and section 411(a)(10) of the Code and the regulations issued thereunder.

(d) *Service preceding a break in service*. For purposes of applying section 203(b)(3)(D) of the Act and section 411(a)(6)(D) of the Code, (relating to counting years of service before a break in service for vesting purposes), the computation periods used by the plan in computing years of service before such break must be the vesting computation periods. (For application of the break in service rules, see section 203(b)(3)(D) and section 411(a)(6)(D) of the Code and regulations issued thereunder.)

§ 2530.203–3 Suspension of pension benefits upon employment.

(a) *General*. Section 203(a)(3)(B) of the Act provides that the right to the employer-derived portion of an accrued pension benefit shall not be treated as forfeitable solely because an employee pension benefit plan provides that the payment of benefits is suspended during certain periods of reemployment which occur subsequent to the commencement of payment of such benefits. This section sets forth the circumstances and conditions under which such benefit payments may be suspended. A plan may provide for the suspension of pension benefits which commence prior to the attainment of normal retirement age, or for the suspension of that portion of pension benefits which exceeds the normal retirement benefit, or both, for any reemployment and without regard to the provisions of section 203(a)(3)(B) and this regulation to the extent (but only to the extent) that suspension of such benefits does not affect a retiree's entitlement to normal retirement benefits payable after attainment of normal retirement age, or the actuarial equivalent thereof.

(b) *Suspension rules*—(1) *General rule*. A plan may provide for the permanent withholding of an amount which does not exceed the suspendible amount of an employee's accrued benefit for each calendar month, or for each four or five week payroll period ending in a calendar month, during which an employee is employed in ''section 203(a)(3)(B) service'' as described in § 2530.203–3(c).

(2) *Resumption of payments*. If benefit payments have been suspended pursuant to paragraph (b)(1) of this section, payments shall resume no later than the first day of the third calendar month after the calendar month in

which the employee ceases to be employed in section 203(a)(3)(B) service: *Provided*, That the employee has complied with any reasonable procedure adopted by the plan for notifying the plan that he has ceased such employment. The initial payment upon resumption shall include the payment scheduled to occur in the calendar month when payments resume and any amounts withheld during the period between the cessation of employment and the resumption of payments, less any amounts which are subject to offset.

(3) *Offset rules*. A plan which provides for the permanent withholding of benefits may deduct from benefit payments to be made by the plan payments previously made by the plan during those calendar months or pay periods in which the employee was employed in section 203(a)(3)(B) service, *Provided*, That such deduction or offset does not exceed in any one month 25 percent of that month's total benefit payment which would have been due but for the offset (excluding the initial payment described in paragraph (b)(2) of this section, which may be subject to offset without limitation).

(4) *Notification*. No payment shall be withheld by a plan pursuant to this section unless the plan notifies the employee by personal delivery or first class mail during the first calendar month or payroll period in which the plan withholds payments that his benefits are suspended. Such notification shall contain a description of the specific reasons why benefit payments are being suspended, a general description of the plan provisions relating to the suspension of payments, a copy of such provisions, and a statement to the effect that applicable Department of Labor regulations may be found in § 2530.203–3 of the Code of Federal Regulations. In addition, the suspension notification shall inform the employee of the plan's procedure for affording a review of the suspension of benefits. Requests for such reviews may be considered in accordance with the claims procedure adopted by the plan pursuant to section 503 of the Act and applicable regulations. In the case of a plan which requires the filing of a benefit resumption notice as a condition precedent to the resumption of benefits, the suspension notification shall also describe the procedure for filing such notice and include the forms (if any) which must be filed. Furthermore, if a plan intends to offset any suspendible amounts actually paid during the periods of employment in section 203(a)(3)(B) service, the notification shall identify specifically the periods of employment, the suspendible amounts which are subject to offset, and the manner in which the plan intends to offset such suspendible amounts. Where the plan's summary plan description (SPD) contains information which is substantially the same as information required by this paragraph (b)(4), the suspension notification may refer the employee to relevant pages of the SPD for information as to a particular item, provided the employee is informed how to obtain a copy of the SPD, or relevant pages thereof, and provided requests for referenced information are honored within a reasonable period of time, not to exceed 30 days.

(5) *Verification*. A plan may provide that an employee must notify the plan of any employment. A plan may request from an employee access to reasonable information for the purpose of verifying such employment. Furthermore, a plan may provide that an employee must, at such time and with such frequency as may be reasonable, as a condition to receiving future benefit payments, either certify that he is unemployed or provide factual information sufficient to establish that any employment does not constitute section 203(a)(3)(B) service if specifically requested by the plan administrator. Once an employee has furnished the required certification or information, the plan must forward, at the next regularly scheduled time for payment of benefits, all payments which had been withheld pursuant to this paragraph (b)(5) except to the extent that payments may be withheld and offset pursuant to other provisions of this regulation.

(6) *Status determination*. If a plan provides for benefits suspension, the plan shall adopt a procedure, and so inform employees, whereunder an employee may request, and the plan administrator in a reasonable amount of time will render, a determination of whether

specific contemplated employment will be section 203(a)(3)(B) service for purposes of plan provisions concerning suspension of benefits. Requests for status determinations may be considered in accordance with the claims procedure adopted by the plan pursuant to section 503 of the Act and applicable regulations.

(7) *Presumptions.* (i) A plan which has adopted verification requirements described in paragraph (b)(5) of this section, and which complies with the notice requirements set forth in paragraph (b)(7)(ii) of this section may provide that whenever the plan fiduciaries become aware that a retiree is employed in section 203(a)(3)(B) service and the retiree has not complied with the plan's reporting requirements with regard to that employment, the plan fiduciaries may, unless it is unreasonable under the circumstances to do so, act on the basis of a rebuttable presumption that the retiree had worked a period exceeding the plan's minimum number of hours for that month. In addition, a plan covering persons employed in the building trades which has adopted verification requirements described in paragraph (b)(5) of this section and which complies with the notice requirements set forth in paragraph (b)(7)(ii) of this section may provide that whenever the plan fiduciaries become aware that a retiree is employed in section 203(a)(3)(B) service at a construction site and the retiree has not complied with the plan's reporting requirements with regard to that employment, then the plan fiduciaries may, unless it is unreasonable under the circumstances to do so, act on the basis of a rebuttable presumption that the retiree engaged in such employment for the same employer in work at that site for so long before the work in question as that same employer performed that work at that construction site.

(ii) A plan which provides for a presumption described in paragraph (b)(7)(i) of this section may employ such presumption only if the following requirements are met. The plan must describe its employment verification requirements and the nature and effect of such presumption in the plan's summary plan description and in any communication to plan participants which relates to such verification requirements (for example, employment reporting reminders or forms), and retirees must be furnished such disclosure, whether through receipt of the above communications or by special distribution, at least once every 12 months.

(c) *Section 202(a)(3)(B) service*—(1) *Plans other than multiemployer plans.* In the case of a plan other than a multiemployer plan, as defined in section 3(37) of the Act, the employment of an employee, subsequent to the time the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment, results in section 203(a)(3)(B) service during a calendar month, or during a four or five week payroll period ending in a calendar month, if the employee, in such month or payroll period,

(i) Completes 40 or more hours of service (as defined in 29 CFR 2530.200b–2(a)(1) and (2)) for an employer which maintains the plan, including employers described in § 2530.210 (d) and (e), as of the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment; or

(ii) Receives from such employer payment for any such hours of service performed on each of 8 or more days (or separate work shifts) in such month or payroll period, *Provided*, That the plan has not for any purpose determined or used the actual number of hours of service which would be required to be credited to the employee under § 2530.200b–(2)(a).

(2) *Multiemployer plans.* In the case of a multiemployer plan, as defined in section 3(37) of the Act, the employment of an employee subsequent to the time the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment results in section 203(a)(3)(B) service during a calendar month, or during a four or five week payroll period ending in a calendar month, if the employee, in such month or payroll period:

—Completes 40 or more hours of service (as defined in § 2530.200b–2(a)(1) and (2)) or

—Receives payment for any such hours of service performed on each of 8 or more days (or separate work shifts) in such month or payroll period, *Provided,* That the plan has not for any purpose determined or used the actual number of hours of service which would be required to be credited to the employee under § 2530.200(b)–(2)(a); in

—An industry in which employees covered by the plan were employed and accrued benefits under the plan as a result of such employment at the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment, and

—A trade or craft in which the employee was employed at any time under the plan, and

—The geographic area covered by the plan at the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment.

(i) *Industry.* The term ''industry'' means the business activities of the types engaged in by any employers maintaining the plan.

Example. One of the employers contributing to a multiemployer plan engages in heavy construction, another in textile manufacturing, and another in communications. Employee E began his career as an employee of an employer engaged in heavy construction. Later E was employed by an employer in communications. With both employers, E accrued benefits under the plan. If E retires and then becomes reemployed in the same trade or craft and in the same geographic area, employment by E in either heavy construction, communications or textile manufacturing, whether or not with an employer who contributes to the plan or in a self-employed capacity, may be considered by the plan to be employment in the same industry, assuming that employees covered by the plan were accruing benefits as a result of employment in these industries at the time E commenced receiving benefits. This is true even though E did not previously accrue benefits as a result of employment with an employer engaged in textile manufacturing because other employees covered by the plan were employed in that industry and were accruing benefits under the plan as a result of such employment at the time when benefit payments to E commenced or would have commenced if E had not returned to employment.

(ii) *Trade or craft.* A trade or craft is (A) a skill or skills, learned during a significant period of training or practice, which is applicable in occupations in some industry, (B) a skill or skills relating to selling, retailing, managerial, clerical or professional occupations, or (C) supervisory activities relating to a skill or skills described in (A) or (B) of this paragraph (c)(2)(ii). For purposes of this paragraph (c)(2)(ii), the determination whether a particular job classification, job description or industrial occupation constitutes or is included in a trade or craft shall be based upon the facts and circumstances of each case. Factors which may be examined include whether there is a customary and substantial period of practical, on-the-job training or a period of related supplementary instruction. Notwithstanding any other factor, the registration of an apprenticeship program with the Bureau of Apprenticeship and Training of the Employment Training Administration of the U.S. Department of Labor is sufficient for the conclusion that a skill or skills which is the subject of the apprenticeship program constitutes a trade or craft.

Example. Participation in a multiemployer plan is limited solely to electricians. Electrician E retired and then became reemployed as a foreman of electricians. Because a ''trade or craft'' includes related supervisory activities, E remains within his trade or craft for purposes of this section.

(iii) *Geographic area covered by the plan.* (A) With the exception of a plan covering employees in a maritime industry, the ''geographic area covered by the plan'' consists of any state or any province of Canada in which contributions were made or were required to be made by or on behalf of an employer and the remainder of any Standard Metropolitan Statistical Area (SMSA) which falls in part within such state, determined as of the time that the payment of benefits commenced or would have commenced if the employee had not returned to employment.

Example. A multiemployer plan covers plumbers in Pennsylvania. All contributing employers have always been located within Pennsylvania. Accordingly, the ''geographic area covered by the plan'' consists of Pennsylvania and any SMSAs which fall in part within Pennsylvania. Thus, for example, in the case of the Philadelphia SMSA, Burlington, Camden and Gloucester Counties in New Jersey are within the ''geographic area covered by the plan''.

(B) [Reserved—for definition of the geographic area covered by a plan that

covers employees in a maritime industry.]

For purposes of this paragraph (c)(2)(iii), contributions shall not include amounts contributed: After December 31, 1978 by or on behalf of an employer where no contributions were made by or on behalf of that employer before that date, if the primary purpose of such contribution is to allow for the suspension of plan benefits in a geographic area not otherwise covered by the plan; or with respect to isolated projects performed in states where plan participants were not otherwise employed.

(3) *Employment in a maritime industry.* For plans covering employees employed in a maritime industry, as defined in § 2530.200b–6, the standard of ''five or more days of service, as defined in § 2530.200b–7(a)(1)'' shall be used in lieu of the standard ''40 or more hours of service'', for purposes of determining whether an employee is employed in section 203(a)(3)(B) service.

(d) *Suspendable amount*—(1) *Life annuity.* In the case of benefits payable periodically on a monthly basis for as long as a life (or lives) continues, such as a straight life annuity or a qualified joint and survivor annuity, a plan may provide that an amount not greater than the portion of a monthly benefit payment derived from employer contributions may be withheld permanently for a calendar month, or for a four or five week payroll period ending in a calendar month, in which the employee is employed in section 203(a)(3)(B) service.

(2) *Other benefit forms.* In the case of benefits payable in a form other than the form described in paragraph (d)(1) of this section, a plan may provide for the permanent withholding of an amount of the employer-derived portion of benefit payments for a calendar month, or for a four or five week payroll period ending in a calendar month, in which the employee is employed in section 203(a)(3)(B) service, not exceeding the lesser of—

(i) The amount of benefits which would have been payable to the employee if he had been receiving monthly benefits under the plan since actual retirement based on a single life annuity commencing at actual retirement age; or

(ii) The actual amount paid or scheduled to be paid to the employee for such month. Payments which are scheduled to be paid less frequently than monthly may be converted to monthly payments for purposes of this paragraph (d)(2)(ii).

(Approved by the Office of Management and Budget under control number 1210–0048)

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§ 2530.204–1 Year of participation for benefit accrual.

(a) *General.* Section 204(b)(1) of the Act and section 411(b)(1) of the Code contain certain requirements relating to benefit accrual under a defined benefit pension plan. Some of these requirements are based on the number of years of participation included in an employee's period of service. Paragraph (b) of this section relates to service which must be taken into account in determining an employee's period of service for purposes of benefit accrual. Section 2530.204–2 sets forth rules relating to the computation periods to be used in measuring years of participation for benefit accrual (''accrual computation periods'').

(b) *Service which may be disregarded for purposes of benefit accrual.* (1) In calculating an employee's period of service for purposes of benefit accrual under a defined benefit pension plan, section 204(b)(3) of the Act and section 411(b)(3) of the Code permit the following service to be disregarded: service before an employee first becomes a participant in the plan; service which is not required to be taken into account under section 202(b) of the Act and section 410(b)(5) of the Code (relating to one-year breaks in service for purposes of eligibility to participate); and service which is not required to be taken into account under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code (relating to 12-consecutive-month periods during which an employee's service is less than 1,000 hours). In addition, in calculating an employee's period of service for purposes of benefit accrual, a defined benefit plan shall not be required

to take into account service before the conclusion of a series of consecutive 1-year breaks in service occurs which permits a plan to disregard prior service under section 203(b)(3)(D) of the Act and section 411(a)(6)(D) of the Code.

(2) *Example*. The following example illustrates paragraph (b)(1) of this section. A plan has a calendar year vesting and accrual computation period and, under § 2530.202–2 (a) and (b)(1), uses eligibility computation periods beginning on an employee's employment commencement date and anniversaries thereof. The plan provides that an employee who has at least 10 years of service has a vested right to 100 percent of his accrued benefit derived from employer contributions. The plan provides that an employee who is credited with at least 1,000 hours of service in a calendar year accrual computation period is credited with at least partial year of participation for purposes of benefit accrual. An employee whose birthday is October 16, 1956, begins employment with an employer maintaining the plan on January 1, 1977. Under § 2530.202–2(a)(1), January 1, 1977 is the employee's employment commencement date and the calendar year 1977 is the employee's initial eligibility computation period. The employee completes at least 1,000 hours of service in each of the calendar years from 1977 through 1981. On January 1, 1982 the employee is admitted to participation in the plan, having met the plan's age requirement (25 years) and service requirement (one year of service) for eligibility to participate. In 1982, the employee is credited with the number of hours of service required for a full year of participation (i.e., more than 1,000 hours of service). Under § 2530.202–2(c), for purposes of applying section 202(b)(4) of the Act and section 410(a)(5)(D) of the Code (relating to years of service completed before a break in service for purposes of eligibility to participate), eligibility computation periods beginning on the employee's employment commencement date and anniversaries thereof are used under the plan to measure service prior to a break in service (in addition, under § 2530.200b–4(a)(2), the same eligibility computation periods are used in measuring one-year breaks in service for purposes of eligibility to participate). Thus, as of January 1, 1983, the employee is credited with six years of service for purposes of eligibility to participate and is credited with one year of participation. In accordance with section 203(b)(1)(A) of the Act and section 411(a)(4)(A) of the Code, the plan provides that years of service completed before age 22 are disregarded for purposes of vesting. As of January 1, 1983, therefore, the employee is credited with four years of service for purposes of vesting. In 1983 the employee terminates employment with the employer, incurring one-year breaks in service in each of the calendar years from 1983 through 1986. As of December 31, 1986, the employee's consecutive one-year breaks in service equal the employee's four years of service for vesting before such breaks. Under section 203(b)(3)(D) of the Act and section 410(a)(5)(D) of the Code and the terms of the plan, the four years of service for vesting completed by the employee before his four consecutive one-year breaks in service are not taken into account for purposes of vesting. Under paragraph (b)(1) of this section, therefore, in calculating the employee's period of service for purposes of benefit accrual, the plan may disregard the year of participation completed by the employee before his four consecutive one-year breaks in service for vesting, because the four consecutive one-year breaks in service equal the four years of service credited to the employee for vesting. The employee is re-employed by the employer on January 1, 1987 completing an hour of service on that date. Under § 2530.200b–4(b)(1), therefore, January 1, 1987 is the employee's reemployment commencement date. In 1987, the employee completes the number of hours of service required for a full year of participation (i.e., more than 1,000 hours of service). For 1987, therefore, the employee is credited with a year of service for purposes of eligibility to participate and vesting, and with a year of participation. As of December 31, 1987, the employee is credited with one year of service for purposes of vesting, since service before the employee's four consecutive one-year breaks in service—including the year of service completed in 1982—

is not taken into account. Because under paragraph (b)(1) of this section, the year of participation credited to the employee for 1982 is not required to be taken into account for purposes of benefit accrual, the employee is credited with one year of participation as of December 31, 1987.

§ 2530.204–2 Accrual computation period.

(a) *Designation of accrual computation periods.* A plan may designate any 12-consecutive-month period as the accrual computation period except that the period so designated must apply equally to all participants. This requirement may be satisfied even though the actual time periods are not the same for all participants. For example, the accrual computation period may be designated as the vesting computation period, the plan year, or the 12-consecutive-month period beginning on either of two semi-annual dates designated for entry to participation under a plan.

(b) *Participation prior to effective date.* For purposes of applying the accrual rules of section 204(b)(1)(D) of the Act and section 411(b)(1)(D) of the Code (relating to accrual requirements for defined benefit plans for periods prior to the effective date of those sections), all service from the date of participation in the plan as determined in accordance with applicable plan provisions, shall be taken into account in determining an employee's period of service. When the plan documents do not provide a definite means for determining the date of commencement of participation, the date of commencement of employment covered under the plan during the period that the employer maintained the plan shall be presumed to be the date of commencement of participation in the plan. The plan may rebut this presumption by demonstrating from circumstances surrounding the operation of the plan, such as the date of commencement of mandatory employee contributions, that participation actually began on a later date.

(c) *Partial year of participation.* (1) Under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code, in calculating an employee's period of service for purposes of benefit accrual, a plan is not required to take into account a 12-consecutive-month period during which the employee's service is less than 1,000 hours of service. In measuring an employee's service for purposes of section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code, a plan shall use the accrual computation period designated under paragraph (a) of this section. Under section 204(b)(3)(B) of the Act and section 411(b)(3)(B) of the Code, in the case of an employee whose service is not less than 1,000 hours of service during an accrual computation period, the calculation of such employee's period of service will not be treated as made on a reasonable and consistent basis unless service during such computation period is taken into account. To the extent that the employee's service during the accrual computation period is less than the service required under the plan for a full year of participation, the employee must be credited with a partial year of participation equivalent to no less than a ratable portion of a full year of participation.

(2) For purposes of calculating the portion of a full year of participation to be credited to an employee whose service during a computation period is not less than 1,000 hours of service but is less than service required for a full year of participation in the plan, the plan may credit the employee with a greater portion of a full year of participation than a ratable portion, or may credit an employee with a full year of participation even though the employee's service is less than the service required for a full year of participation, provided that such crediting is reasonable and is consistent for all employees within the same job classifications, reasonably established.

(3) In the case of an employee who commences participation in a plan (or recommences participation in the plan upon the employee's return after one or more 1-year breaks in service) on a date other than the first day of an applicable accrual computation period, all hours of service required to be credited to the employee during the entire accrual computation period, including

hours of service credited to the employee for the portion of the computation period before the date on which the employee commences (or recommences) participation, shall be taken into account in determining whether the employee has 1,000 or more hours of service for purposes of section 204(b)(3)(C) of the Act and section 411(b)3)(C) of the Code. If such employee's service is not less than 1,000 hours in such accrual computation period, the employee must be credited with a partial year of participation which is equivalent to no less than a ratable portion of a full year of participation for service credited to the employee for the portion of the computation period after the date of commencement (or recommencement) of participation.

(4) *Examples*. The following are examples of reasonable and consistent methods for crediting partial years of participation:

(i) A plan requires 2,000 hours of service for a full year of participation. An employee who is credited during a computation period with no less than 1,000 hours of service but less than 2,000 hours of service is credited with a partial year of participation equal to a portion of a full year of participation determined by dividing the number of hours of service credited to the employee by 2,000.

(ii) A plan requires 2,000 hours of service for a full year of participation. The plan credits service in an accrual computation period in accordance with the following table:

Hours of service credited	Percentage of full year of participation credited
1000	50
1001 to 1200	60
1201 to 1400	70
1401 to 1600	80
1601 to 1800	90
1801 and above	100

Under this method of crediting partial years of participation, each employee who is credited with not less than 1,000 hours of service is credited with at least a ratable portion of a full year of participation.

(iii) A plan provides that each employee who is credited with at least 1,000 hours of service in an accrual computation period must receive credit for at least a partial year of participation for that computation period. For full accrual, however, the plan requires that an employee must be credited with a specified number of hours worked; employees who meet the 1,000 hours of service requirement but who are not credited with the specified number of hours worked required for a full year of participation are credited with a partial year of participation on a prorata basis. For example, if the plan requires 1,500 hours worked for full accrual, an employee with 1,500 hours worked would be credited with full accrual, but an employee with 1,000 hours worked and 500 other hours of service would be credited with ⅔ of full accrual. The plan's method of crediting service for accrual purposes is consistent with the requirements of this paragraph. It should be noted, however, that use of hours worked as a basis for prorating benefit accrual may result in discrimination prohibited under section 401(a)(4) of the Code.

(iv) Employee A is employed on June 1, 1980 in service covered by a plan with a calendar year accrual computation period, and which requires 1,800 hours of service for a full accrual. Employee A completes 500 hours from June 1, 1980 to December 31, 1980, and completes 100 hours per month in each month during 1981. A is admitted to participation on July 1, 1981. A is credited with 1,200 hours of service for the accrual computation period beginning January 1, 1981. Under the rules set forth in paragraph (c)(3) of this section, A is required to be credited with not less than one-third of a full accrual (600 hours divided by 1,800 hours).

(d) *Prohibited double proration*. (1) In the case of a defined benefit plan that (i) defines benefits on a basis which has the effect of prorating benefits to reflect less than full-time employment or less than maximum compensation and (ii) does not adjust less-than-full-time service to reflect the equivalent of full-time hours or compensation (as the case may be), the plan may not further prorate benefit accrual under section 204(b)(3)(B) of the Act and section 411(b)(3)(B) of the Code by crediting less than full years of participation, as would otherwise be permitted under paragraph (c) of this section. These

plans must credit, except when service may be disregarded under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code (relating to less than 1,000 hours of service), less-than-full-time employees with a full year of participation for the purpose of accrual of benefits.

(2) *Examples*. (i) A plan's defined benefit formula provides that the annual retirement benefit shall be 2 percent of the average compensation in all years of participation multiplied by the number of years of participation. Employee A is a full-time employee who has completed 2,000 hours during each of 20 accrual computation periods. A's average hourly rate was $5 an hour. Thus, A's average compensation for each year during participation in the plan is $10,000 ($5 per hour multiplied by 2,000 hours). If the plan states that a full year of participation is 2,000 hours, then A's annual retirement benefits, if he retired at that time, would be $4,000 ($10,000 per year of compensation ×.02×20 years of participation). Employee B, however, is a part-time employee who completes 1,000 hours of service during each of 20 accrual computation periods. Like A, B's average hourly rate is $5 per hour. B's average compensation for his total years of participation is $5,000 ($5 per hour multiplied by 1,000 hours). Thus, the plan's benefit formula, by basing benefits on an employee's average compensation in all years of participation, in effect prorates benefits to reflect the fact that during B's participation in the plan, he has earned less than the maximum compensation that a full-time employee paid at the same rate could earn during the same period of participation in the plan. Under the rule of subparagraph (1), therefore, the plan is not permitted to prorate B's years of participation to reflect B's less than full-time employment throughout his participation in the plan. Therefore, B's annual retirement benefit would be $2,000 ($5,000 average compensation ×.02×20 years of participation). (If double proration were permitted, then B's total years of participation would be only 10 since he would be credited with only one-half of a year of participation during each of the accrual computation periods (1,000/2,000). Thus, B's annual retirement benefit would be $1,000—i.e., $5,000 average compensation ×.02×10 years of participation.)

(ii) If the plan adjusts the average compensation during plan participation to reflect full compensation, then the plan may prorate years of participation. Thus, the average full annual compensation for B would be $10,000 rather than the $5,000 actually paid. Employee B's annual retirement benefit would then be $2,000 ($10,000 average full compensation ×.02×10 years of participation).

(e) *Amendments to change accrual computation periods*. (1) A plan may be amended to change the accrual computation period to a different 12-consecutive-month period, provided that the period between the end of the last accrual computation period under the plan as in effect before such amendment and the beginning of the first accrual computation period under the plan as amended is treated as a partial accrual computation period in accordance with the rules set forth in paragraph (e)(2) of this section.

(2) In the case of a partial accrual computation period, the following rules shall apply:

(i) A plan having a minimum service requirement expressed in hours of service (or other units of service) for benefit accrual in a full accrual computation period (as permitted under section 204(b)(3)(B) of the Act and section 411(b)(3)(B) of the Code) may apply a minimum service requirement for benefit accrual in a partial accrual computation period which is equal to the plan's minimum service requirement for benefit accrual in a full accrual computation period, multiplied by the ratio of the length of the partial accrual computation period to a full year.

(ii) In the case of a participant who meets a plan's minimum service requirement for benefit accrual in a partial accrual computation period (as permitted under paragraph (e)(2)(i) of this section), the plan shall credit the participant with at least a partial year of participation for purposes of benefit accrual. Credit for a partial accrual computation period shall be determined in accordance with paragraphs (c) and (d) of this section.

(3) *Example.* Effective October 1, 1977, a plan is amended to change the accrual computation period from the 12-consecutive-month period beginning on January 1 to the 12-consecutive-month period beginning on October 1. The period from January 1, 1977 to September 30, 1977 must be treated as a partial accrual computation period. The plan has a requirement that a participant must be credited with 1,000 hours of service in an accrual computation period in order to be credited with a year of participation for purposes of benefit accrual. For the partial accrual computation period the plan may require a participant to be credited with 750 hours of service in the partial accrual computation period in order to receive credit for purposes of benefit accrual (1,000 hours of service multiplied by the ratio of 9 months to 12 months). To the extent permitted under paragraph (d) of this section, the plan may prorate accrual credit on whatever basis the plan uses to prorate accrual credit for employees whose service is 1,000 hours of service or more but less than service required for full accrual in a full accrual computation period.

§ 2530.204–3 Alternative computation methods for benefit accrual.

(a) *General.* Under section 204(b)(3)(A) of the Act and section 411(b)(3)(A) of the Code, a defined benefit pension plan may determine an employee's service for purposes of benefit accrual on the basis of accrual computation periods, as specified in § 2530.204–2, or on any other basis which is reasonable and consistent and which takes into account all covered service during the employee's participation in the plan which is included in a period of service required to be taken into account under section 202(b) of the Act and section 410(a)(5) of the Code. If, however, a plan determines an employee's service for purposes of benefit accrual on a basis other than computation periods, it must be possible to prove that, despite the fact that benefit accrual under the plan is not based on computation periods, the plan's provisions meet at least one of the three benefit accrual rules of section 204(b)(1) of the Act and section 411(b)(1) of the Code under all circumstances. Further, a plan which does not provide for benefit accrual on the basis of computation periods may not disregard service under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code.

(b) *Examples.* The following are examples of methods of determining an employee's period of service for purposes of benefit accrual under which an employee's period of service is not determined on the basis of computation periods but which may be used by a plan provided that the requirements of paragraph (a) of this section are met:

(1) *Career compensation.* A defined benefit formula based on a percentage of compensation earned in a participant's career or during participation, with no variance depending on hours completed in given periods.

(2) *Credited hours.* A defined benefit formula pursuant to which an employee is credited with a specified amount of accrual for each hour of service (or hour worked or regular time hour) completed by the employee during his or her career.

(3) *Elapsed time.* See § 2530.200b–9(e).

§ 2530.204–4 Deferral of benefit accrual.

For purposes of section 204(b)(1)(E) of the Act and section 411(b)(1)(E) of the Code (which permit deferral of benefit accrual until an employee has 2 continuous years of service), an employee shall be credited with a year of service for each computation period in which he or she completes 1,000 hours of service. The computation period shall be the eligibility computation period designated in accordance with § 2530.202–2.

Subpart C—Form and Payment of Benefits

§§ 2530.205–2530.206 [Reserved]

Subpart D—Plan Administration as Related to Benefits

§§ 2530.207–2530.209 [Reserved]

§ 2530.210 Employer or employers maintaining the plan.

(a) *General statutory provisions*—(1) *Eligibility to participate and vesting.* Except as otherwise provided in section

202(b) or 203(b)(1) of the Act and sections 410(a)(5), 411(a)(5) and 411(a)(6) of the Code, all years of service with the employer or employers maintaining the plan shall be taken into account for purposes of section 202 of the Act and section 410 of the Code (relating to minimum eligibility standards) and section 203 of the Act and section 411(a) of the Code (relating to minimum vesting standards).

(2) *Accrual of benefits.* Except as otherwise provided in section 202(b) of the Act and section 410(a)(5) of the Code, all years of participation under the plan must be taken into account for purposes of section 204 of the Act and section 411(b) of the Code (relating to benefit accrual). Section 204(b) of the Act and section 411(b) of the Code require only that periods of actual participation in the plan (e.g., covered service) be taken into account for purposes of benefit accrual.

(b) *General rules concerning service to be credited under this section.* Section 210 of the Act and sections 413(c), 414(b), and 414(c) of the Code provide rules applicable to sections 202, 203, and 204 of the Act and sections 410, 411(a), and 411(b) of the Code for purposes of determining who is an ''employer or employers maintaining the plan'' and, accordingly, what service is required to be taken into account in the case of a plan maintained by more than one employer. Paragraphs (c) through (e) of this section set forth the rules for determining service required to be taken into account in the case of a plan or plans maintained by multiple employers, controlled groups of corporations and trades or businesses under common control. Note throughout that every mention of multiple employer plans includes multiemployer plans. See § 2530.210(c)(3). Paragraph (f) of this section sets forth special break in service rules for such plans. Paragraph (g) of this section applies the break in service rules of sections 202(b)(4) and 203(b)(3)(D) of the Act and sections 410(a)(5)(D) and 411(a)(6)(D) of the Code (rule of parity) to such plans.

(c) *Multiple employer plans*—(1) *Eligibility to participate and vesting.* A multiple employer plan shall be treated as if all maintaining employers constitute a single employer so long as an employee is employed in either covered service or contiguous noncovered service. Accordingly, except as referred to in paragraph (a)(1) and provided in paragraph (f) of this section, in determining an employee's service for eligibility to participate and vesting purposes, all covered service with an employer or employers maintaining the plan and all contiguous noncovered service with an employer or employers maintaining the plan shall be taken into account. Thus, for example, if an employee in service covered under a multiple employer plan leaves covered service with one employer maintaining the plan and is employed immediately thereafter in covered service with another employer maintaining the plan, the plan is required to credit all hours of service with both employers for purposes of participation and vesting. If an employee moves from contiguous noncovered to covered service, or from covered service to contiguous noncovered service, with the same employer, the plan is required to credit all hours of service with such employer for purposes of eligibility to participate and vesting.

(2) *Benefit accrual.* A multiple employer plan shall be treated as if all maintaining employers constitute a single employer so long as an employee is employed in covered service. Accordingly, except as referred to in paragraph (a)(2) and provided in paragraph (f) of this section, in determining a participant's service for benefit accrual purposes, all covered service with an employer or employers maintaining the plan shall be taken into account.

(3) *Definitions.* (i) For purposes of this section, the term ''multiple employer plan'' shall mean a multiemployer plan as defined in section 3(37) of the Act and section 414(f) of the Code or a multiple employer plan within the meaning of sections 413 (b) and (c) of the Code and the regulations issued thereunder. Notwithstanding the preceding sentence, a plan maintained solely by members of the same controlled group of corporations within the meaning of paragraph (d) of this section or by trades or businesses which are under the common control of one person or group of persons within the meaning of paragraph (e) of this section shall not

be deemed to be a multiple employer plan for purposes of this section, and such plan is required to apply the rules under this section which are applicable to controlled groups of corporations or commonly controlled trades or businesses respectively.

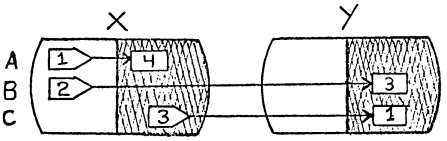
(ii) For purposes of this section, the term ''covered service'' shall mean service with an employer or employers maintaining the plan within a job classification or class of employees covered under the plan.

(iii) For purposes of this section the term ''noncovered service'' shall mean service with an employer or employers maintaining the plan which is not covered service.

(iv)(A) *General.* For purposes of this section noncovered service shall be deemed ''contiguous'' if (*1*) the noncovered service precedes or follows covered service and (*2*) no quit, discharge, or retirement occurs between such covered service and noncovered service.

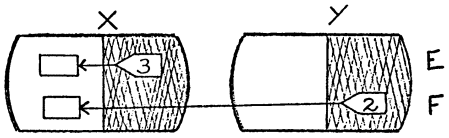
(B) *Exception.* Notwithstanding the preceding paragraph, in the case of a controlled group of corporations within the meaning of paragraph (d) of this section or trades or businesses which are under the common control of one person or group of persons within the meaning of paragraph (e) of this section, any transfer of an employee from one member of the controlled group to another member or from one trade or business under common control to another trade or business under the common control of the same person or group of persons shall result in the period of noncovered service which immediately precedes or follows such transfer being deemed ''noncontiguous'' for purposes of paragraph (c) of this section.

DIAGRAM NO. 1. (MULTIPLE EMPLOYER PLAN.)



Assume for purposes of diagram No. 1 that X and Y are both employers who are required to contribute to a multiple employer plan and that neither employer maintains any other plan. Covered service is represented by the shaded segments of the diagram. After completing 1 year of noncovered service, employee A immediately enters covered service with X and completes 4 years of covered service. For purposes of eligibility to participate and vesting, the plan is required to credit employee A with 5 years of service with employer X because his period of service with X includes a period of covered service and a period of contiguous noncovered service. On the other hand, employee B, immediately after completing 2 years of noncovered service with X, enters covered service with Y. Because B quit employment with X, his period of noncovered service with X is not contiguous and, therefore, is not required to be taken into account. In the case of employee C, the plan is required to take into account all service with employers X and Y because employee C is employed in covered service with both employers.

DIAGRAM NO. 2. (MULTIPLE EMPLOYER.)



The multiple employer plan rules with respect to noncovered service are illustrated in diagram No. 2. Assume that X and Y are both employers who are required to contribute to a multiple employer plan and that neither employer maintains any other plan. Covered service is represented by the shaded segments of the diagram. Employee E completed 3 years of service with employer X in covered service and then immediately entered noncovered service with X. Because E's noncovered service is contiguous, the plan is required to take into account all service with X for purposes of eligibility to participate and vesting under the multiple employer plan. Employee F does not continue to receive credit; F quit the employment of Y and entered noncovered service with X.

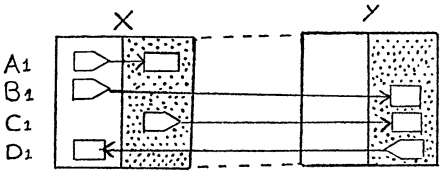
(d) *Controlled groups of corporations.* (1) With respect to a plan maintained by one or more members of a controlled group of corporations (within the meaning of section 1563(a) of the Code, determined without regard to sections 1563(a)(4) and (e)(3)(C), all employees of such corporations shall be treated as employed by a single employer.

(2) Accordingly, except as referred to in paragraph (a)(1) and provided in

paragraph (f) of this section, in determining an employee's service for eligibility to participate and vesting purposes, all service with any employer which is a member of the controlled group of corporations shall be taken into account. Except as referred to in paragraph (a)(2) and provided in paragraph (f) of this section, in determining a participant's service for benefit accrual purposes, all service during periods of participation covered under the plan with any employer which is a member of the controlled group of corporations shall be taken into account.

(e) *Commonly controlled trades or businesses.* With respect to a plan maintained only by one or more trades or businesses (whether or not incorporated) which are under common control within the meaning of section 414(c) of the Code and the regulations issued thereunder, all employees of such trades or businesses shall be treated as employed by a single employer. Accordingly, except as referred to in paragraph (a)(1) and provided in paragraph (f) of this section, in determining an employee's service for eligibility to participate and vesting purposes, all service with any employer which is under common control shall be taken into account. Except as referred to in paragraph (a)(2) and provided in paragraph (f) of this section, in determining a participant's service for benefit accrual purposes, all service during periods of participation covered under the plan with any employer which is under common control shall be taken into account.

Diagram No. 3. (Controlled group or commonly controlled trade or business.)



Assume for purposes of diagram No. 3 that X and Y are either members of the same controlled group of corporations or trades or businesses which are under the same common control. The dotted segments of the diagram represent plan coverage under plans separately maintained by X and Y. Neither employer maintains any other plans. Because A1, B1, C1, and D1 have their service with X and Y treated as if X and Y were a single employer, the plans are required to take into account all service with X and Y for eligibility to participate and vesting purposes.

(f) *Special break in service rules.* (1) In addition to service which may be disregarded under the statutory provisions referred to in paragraph (a) of this section, a multiple employer plan may disregard noncontiguous non- covered service.

(2) In the case of a plan maintained solely by one or more members of a controlled group of corporations or one or more trades or businesses which are under common control, if one of the maintaining employers is also a participating employer in a multiple employer plan which includes other employers which are not members of the controlled group or commonly controlled trades or businesses, service with such other employer maintaining the multiple employer plan may be disregarded by the controlled group or commonly controlled plan.

DIAGRAM NO. 4. (BREAK IN SERVICE RULES.)

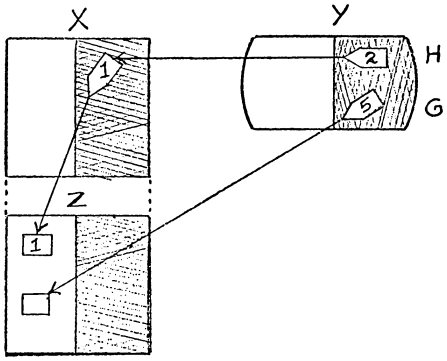


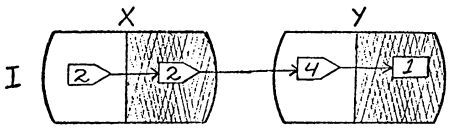
Diagram No. 4 illustrates the break in service rules of paragraph (f) of this section. Assume for purposes of diagram No. 4 that employer Z is controlled by employer X but employer Y's only relation to X and Z is that X, Y, and Z are required to contribute to a multiple employer plan. The multiple employer plan, represented by the shaded segments of the diagram, provides for 100 percent vesting after 10 years. X, Y, and Z maintain no other plans.

Employee G completed 5 years of covered service with employer Y, and then moved to noncovered service with employer Z. G's noncovered service is noncontiguous (see employee F in diagram No. 2 above), and such service may be disregarded for purposes of the multiple employer plan under the rule in paragraph (f)(1).

Employee H completed 2 years of covered service with employer Y and then entered covered service with employer X for 1 year. The multiple employer plan is required to credit H with 3 years of service. H then entered noncovered service with employer Z. H's noncovered service is noncontiguous (see employee F in diagram No. 2 above), and such service may be disregarded for purposes of the multiple employer plan under the rule in paragraph (f)(1).

(g) *Rule of parity*. For purposes of sections 202(b)(4) and 203(b)(3)(D) of the Act and sections 410(a)(5)(D) and 411(a)(6)(D) of the Code, in the case of an employee who is a nonvested participant in employer-derived accrued benefits at the time he incurs a 1-year break in service, years of service completed by such employee before such break are not required to be taken into account if at such time he incurs consecutive 1-year breaks in service which equal or exceed the aggregate number of years of service before such breaks. This is so even though the period of noncontiguous noncovered service with an employer or employers maintaining the plan may subsequently be deemed contiguous as the result of the employee entering covered service with the same employer maintaining the plan and, consequently, such plan may be required to credit such service.

Diagram No. 5. (Rule of parity)



Assume for purposes of diagram No. 5 that X and Y are both employers who are required to contribute to a multiple employer plan which contains a provision applying the rule of parity. Covered service is represented by the shaded segments of the diagram. The plan has 100% vesting after 10 years. X and Y maintain no other plan.

The multiple employer plan credited employee I with 4 years of service with X when he quit employment with X and entered noncovered service with Y. As a result of 4 years of noncontiguous noncovered service with Y, employee I incurred 4 consecutive 1-year breaks in service, so that the multiple employer plan may disregard his prior service (i.e., the 4 years of service with X).

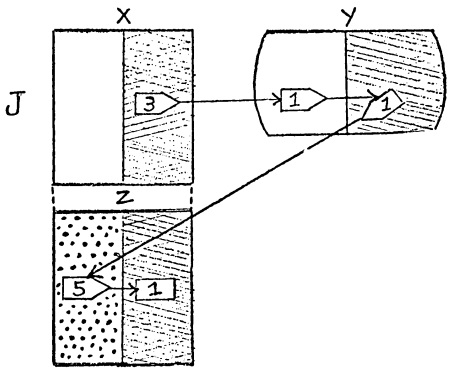
When employee I entered covered service with Y (as a ''new employee''), his 4 years of noncontiguous service with Y became contiguous for purposes of the multiple employer plan. Consequently, after 1 year of covered service with Y, the plan is required to credit employee I with 5 years of service.

(h) *Example*. Under section 203(b)(1)(C) of the Act and section 411(a)(4)(C) of the Code, service with an employer prior to such employer's adoption of the plan need not be taken into account. The following example demonstrates that this rule applies even if an employee is employed in contiguous noncovered service. The example is applicable to any plan subject to the rules of this section. However, for purposes of clarity, the example assumes that X and Y are required to contribute to a multiple employer plan.

Assume that employee D completed 3 years of covered service with employer Y as of the date X adopts the plan. Immediately after X's adoption of the plan D left covered service with Y and D entered covered service with X. His prior covered service with Y is required to be counted, and D remains a participant.

On the other hand, if D had entered service with X any time prior to X's adoption of the plan and subsequently was covered by the plan when X adopted it, his prior service with Y must also be counted, unless such service may be disregarded under the break in service rules because the period of service with X before X's adoption of the plan was equal to or greater than his prior service with Y. For example, if X adopted the plan three years after D began employment with X, and consequently after D had incurred 3 consecutive 1-year breaks in service, his prior service with Y could be disregarded.

(i) Comprehensive diagram. (No. 6)



Assume for purposes of diagram No. 6 that employer Z is controlled by employer X within the meaning of paragraph (d) but employer Y's only relation to X and Z is that X, Y and Z are required to contribute to a multiple employer plan. The shaded segments represent coverage under the multiple employer plan which contains a provision applying the rule of parity. The dotted segment represents a separate plan maintained by Z. Both plans have 100% vesting after 10 years.

Employee J completed 3 years of service with employer X in covered service with the multiple employer plan. J then entered noncovered service with Y and remained with Y for 1 year, and thereby incurred a 1-year break in service under the multiple employer plan. J then entered covered service with employer Y, thereby causing the noncovered service with Y to become contiguous. Covered service with X and contiguous noncovered and covered service with Y must be taken into account for purposes of the multiple employer plan; accordingly, that plan is required to credit J with a total of 5 years of service.

J then left service with Y and entered noncovered service (with respect to the multiple employer plan) with Z. J remained in noncovered service with Z (with respect to the multiple employer plan) for 5 years and thereby incurred 5 consecutive 1-year break in service for purposes of the multiple employer plan. Consequently, the prior service with X and Y may be disregarded for purposes of the multiple employer plan.

J then entered covered service under the multiple employer plan with Z and completed 1 year of service. Because the 5 years of noncovered service with Z is contiguous with the 1 year of covered service, the multiple employer plan is now required to credit J with 6 years of service for purposes of eligibility to participate and vesting.

For purposes of Z's controlled group plan (i.e., dotted segment), employee J is entitled to receive credit for 9 years of service. The 3 years of service with X, a member of the controlled group, may not be disregarded under the rule of parity because J incurred only 2 consecutive 1-year breaks in service while employed with Y. When J entered service with Z covered under Z's controlled group plan, the 3 years of service with X were still required to be credited by the controlled group plan. In addition, J must receive credit for the 5 years of service with Z covered under the controlled group plan. Finally, when J moved to service with Z covered under the multiple employer plan the controlled group plan was required to credit J with an additional year of service.

SUBCHAPTER E [RESERVED]
SUBCHAPTER F—FIDUCIARY RESPONSIBILITY UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2550—RULES AND REGULATIONS FOR FIDUCIARY RESPONSIBILITY

Sec.

2550.401c–1 Definition of ''plan assets''—insurance company general accounts.
2550.403a–1 Establishment of trust.
2550.403b–1 Exemptions from trust requirement.
2550.404a–1 Investment duties.
2550.404b–1 Maintenance of the indicia of ownership of plan assets outside the jurisdiction of the district courts of the United States.
2550.404c–1 ERISA section 404(c) plans.
2550.407a–1 General rule for the acquisition and holding of employer securities and employer real property.
2550.407a–2 Limitation with respect to the acquisition of qualifying employer securities and qualifying employer real property.
2550.407d–5 Definition of the term ''qualifying employer security''.
2550.407d–6 Definition of the term ''employee stock ownership plan''.
2550.408b–1 General statutory exemption for loans to plan participants and beneficiaries who are parties in interest with respect to the plan.
2550.408b–2 General statutory exemption for services or office space.
2550.408b–3 Loans to Employee Stock Ownership Plans.
2550.408b–4 Statutory exemption for investments in deposits of banks or similar financial institutions.
2550.408b–6 Statutory exemption for ancillary services by a bank or similar financial institution.
2550.408c–2 Compensation for services.
2550.408e Statutory exemption for acquisition or sale of qualifying employer securities and for acquisition, sale, or lease of qualifying employer real property.
2550.412–1 Temporary bonding requirements.

AUTHORITY: 29 U.S.C. 1135. Section 2550.401b–1 also issued under sec. 102, Reorganization Plan No. 4 of 1978, 3 CFR, 1978 Comp., p. 332. Section 2550.401c–1 also issued under 29 U.S.C. 1101. Section 2550.404c–1 also issued under 29 U.S.C. 1104. Section 2550.407c–3 also issued under 29 U.S.C. 1107. Section 2550.408b–1 also issued under sec. 102, Reorganization Plan No. 4 of 1978, 3 CFR, 1978 Comp., p. 332, and 29 U.S.C. 1108(b)(1). Section 2550.412–1 also issued under 29 U.S.C. 1112. Secretary of Labor's Order No. 1–87 (52 FR 13139).

§ 2550.401c–1 Definition of "plan assets"—insurance company general accounts.

(a) *In general.* (1) This section describes, in the case where an insurer issues one or more policies to or for the benefit of an employee benefit plan (and such policies are supported by assets of an insurance company's general account), which assets held by the insurer (other than plan assets held in its separate accounts) constitute plan assets for purposes of Subtitle A, and Parts 1 and 4 of Subtitle B, of Title I of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) and section 4975 of the Internal Revenue Code (the Code), and provides guidance with respect to the application of Title I of the Act and section 4975 of the Code to the general account assets of insurers.

(2) Generally, when a plan has acquired a Transition Policy (as defined in paragraph (h)(6) of this section), the plan's assets include the Transition Policy, but do not include any of the underlying assets of the insurer's general account if the insurer satisfies the requirements of paragraphs (c) through (f) of this section or, if the requirements of paragraphs (c) through (f) were not satisfied, the insurer cures the non-compliance through satisfaction of the requirements in paragraph (i)(5) of this section.

(3) For purposes of paragraph (a)(2) of this section, a plan's assets will not include any of the underlying assets of the insurer's general account if the insurer fails to satisfy the requirements of paragraphs (c) through (f) of this section solely because of the takeover of the insurer's operations from management as a result of the granting of a petition filed in delinquency proceedings in the State court where the insurer is domiciled.

(b) *Approval by fiduciary independent of the issuer.* (1) *In general.* An independent plan fiduciary who has the authority to manage and control the assets of the plan must expressly authorize the acquisition or purchase of the Transition Policy. For purposes of this paragraph, a fiduciary is not independent if the fiduciary is an affiliate of the insurer issuing the policy.

(2) Notwithstanding paragraph (b)(1) of this section, the authorization by an independent plan fiduciary is not required if:

(i) The insurer is the employer maintaining the plan, or a party in interest which is wholly owned by the employer maintaining the plan; and

(ii) The requirements of section 408(b)(5) of the Act are met.[1]

(c) *Duty of disclosure.* (1) *In general.* An insurer shall furnish the information described in paragraphs (c)(3) and (c)(4) of this section to a plan fiduciary acting on behalf of a plan to which a Transition Policy has been issued. Paragraph (c)(2) of this section describes the style and format of such disclosure. Paragraph (c)(3) of this section describes the content of the initial disclosure. Paragraph (c)(4) of this section describes the information that must be disclosed by the insurer at least once per year for as long as the Transition Policy remains outstanding.

(2) *Style and format.* The disclosure required by this paragraph should be clear and concise and written in a manner calculated to be understood by a plan fiduciary, without relinquishing any of the substantive detail required by paragraphs (c)(3) and (c)(4) of this section. The information does not have to be organized in any particular order but should be presented in a manner which makes it easy to understand the operation of the Transition Policy.

(3) *Initial disclosure.* The insurer must provide to the plan, either as part of an amended policy, or as a separate written document, the disclosure information set forth in paragraphs (c)(3)(i) through (iv) of this section. The disclosure must include all of the following information which is applicable to the Transition Policy:

(i) A description of the method by which any income and any expense of the insurer's general account are allocated to the policy during the term of the policy and upon its termination, including:

(A) A description of the method used by the insurer to determine the fees, charges, expenses or other amounts that are, or may be, assessed against the policyholder or deducted by the insurer from any accumulation fund under the policy, including the extent and frequency with which such fees, charges, expenses or other amounts may be modified by the insurance company;

(B) A description of the method by which the insurer determines the return to be credited to any accumulation fund under the policy, including a description of the method used to allocate income and expenses to lines of business, business segments, and policies within such lines of business and business segments, and a description of how any withdrawals, transfers, or payments will affect the amount of the return credited;

(C) A description of the rights which the policyholder or plan participants have to withdraw or transfer all or a portion of any accumulation fund under the policy, or to apply the amount of a withdrawal to the purchase of guaranteed benefits or to the payment of benefits, and the terms on which such withdrawals or other applications of funds may be made, including a description of any charges, fees, credits, market value adjustments, or any other charges or adjustments, both positive and negative;

(D) A statement of the method used to calculate any charges, fees, credits or market value adjustments described in paragraph (c)(3)(i)(C) of this section, and, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request:

(*1*) The formula actually used to calculate the market value adjustment, if any, to be applied to the unallocated

[1] The Department notes that, because section 401(c)(1)(D) of the Act and the definition of Transition Policy preclude the issuance of any additional Transition Policies after December 31, 1998, the requirement for independent fiduciary authorization of the acquisition or purchase of the Transition Policy in paragraph (b) no longer has any application.

amount in the accumulation fund upon distribution of a lump sum payment to the policyholder, and

(*2*) The actual calculation, as of a specified date that is no earlier than the last contract anniversary preceding the date of the request, of the applicable market value adjustment, including a description of the specific variables used in the calculation, the value of each of the variables, and a general description of how the value of each of those variables was determined.

(*3*) If the formula is based on interest rate guarantees applicable to new contracts of the same class or classes, and the duration of the assets underlying the accumulation fund, the contract must describe the process by which those components are ascertained or obtained. If the formula is based on an interest rate implicit in an index of publicly traded obligations, the identity of the index, the manner in which it is used, and identification of the source or publication where any data used in the formula can be found, must be disclosed;

(ii) A statement describing the expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer's right, if any, to modify or eliminate such guarantees;

(iii) A description of the rights of the parties to make or discontinue contributions under the policy, and of any restrictions (such as timing, minimum or maximum amounts, and penalties and grace periods for late payments) on the making of contributions under the policy, and the consequences of the discontinuance of contributions under the policy; and

(iv) A statement of how any policyholder or participant-initiated withdrawals are to be made: first-in, first-out (FIFO) basis, last-in, first-out (LIFO) basis, pro rata or another basis.

(4) *Annual disclosure.* At least annually and not later than 90 days following the period to which it relates, an insurer shall provide the following information to each plan to which a Transition Policy has been issued:

(i) The balance of any accumulation fund on the first day and last day of the period covered by the annual report;

(ii) Any deposits made to the accumulation fund during such annual period;

(iii) An itemized statement of all income attributed to the policy or added to the accumulation fund during the period, and a description of the method used by the insurer to determine the precise amount of income;

(iv) The actual rate of return credited to the accumulation fund under the policy during such period, stating whether the rate of return was calculated before or after deduction of expenses charged to the accumulation fund;

(v) Any other additions to the accumulation fund during such period;

(vi) An itemized statement of all fees, charges, expenses or other amounts assessed against the policy or deducted from the accumulation fund during the reporting year, and a description of the method used by the insurer to determine the precise amount of the fees, charges and other expenses;

(vii) An itemized statement of all benefits paid, including annuity purchases, to participants and beneficiaries from the accumulation fund;

(viii) The dates on which the additions or subtractions were credited to, or deducted from, the accumulation fund during such period;

(ix) A description, if applicable, of all transactions with affiliates which exceed 1 percent of group annuity reserves of the general account for the prior reporting year;

(x) A statement describing any expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer's right, if any, to modify or eliminate such guarantees. However, the information on guarantees does not have to be provided annually if it was previously disclosed in the insurance policy and has not been modified since that time;

(xi) A good faith estimate of the amount that would be payable in a lump sum at the end of such period pursuant to the request of a policyholder for payment or transfer of amounts in the accumulation fund under the policy after the insurer deducts any applicable charges and makes any appropriate market value

adjustments, upward or downward, under the terms of the policy. However, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request the information contained in paragraph (c)(3)(i)(D) as of a specified date that is no earlier than the last contract anniversary preceding the date of the request; and

(xii) An explanation that the insurer will make available promptly upon request of a plan, copies of the following publicly available financial data or other publicly available reports relating to the financial condition of the insurer:

(A) National Association of Insurance Commissioners Statutory Annual Statement, with Exhibits, General Interrogatories, and Schedule D, Part 1A, Sections 1 and 2 and Schedule S—Part 3E;

(B) Rating agency reports on the financial strength and claims-paying ability of the insurer;

(C) Risk adjusted capital ratio, with a brief description of its derivation and significance, referring to the risk characteristics of both the assets and the liabilities of the insurer;

(D) Actuarial opinion of the insurer's Appointed Actuary certifying the adequacy of the insurer's reserves as required by New York State Insurance Department Regulation 126 and comparable regulations of other States; and

(E) The insurer's most recent SEC Form 10K and Form 10Q (stock companies only).

(d) *Alternative separate account arrangements.* (1) *In general.* An insurer must provide the plan fiduciary with the following additional information at the same time as the initial disclosure required under paragraph (c)(3) of this section:

(i) A statement explaining the extent to which alternative contract arrangements supported by assets of separate accounts of insurers are available to plans;

(ii) A statement as to whether there is a right under the policy to transfer funds to a separate account and the terms governing any such right; and

(iii) A statement explaining the extent to which general account contracts and separate account contracts of the insurer may pose differing risks to the plan.

(2) An insurer will be deemed to comply with the requirements of paragraph (d)(1)(iii) of this section if the disclosure provided to the plan includes the following statement:

a. Contractual arrangements supported by assets of separate accounts may pose differing risks to plans from contractual arrangements supported by assets of general accounts. Under a general account contract, the plan's contributions or premiums are placed in the insurer's general account and commingled with the insurer's corporate funds and assets (excluding separate accounts and special deposit funds). The insurance company combines in its general account premiums received from all of its lines of business. These premiums are pooled and invested by the insurer. General account assets in the aggregate support the insurer's obligations under all of its insurance contracts, including (but not limited to) its individual and group life, health, disability, and annuity contracts. Experience rated general account policies may share in the experience of the general account through interest credits, dividends, or rate adjustments, but assets in the general account are not segregated for the exclusive benefit of any particular policy or obligation. General account assets are also available to the insurer for the conduct of its routine business activities, such as the payment of salaries, rent, other ordinary business expenses and dividends.

b. An insurance company separate account is a segregated fund which is not commingled with the insurer's general assets. Depending on the particular terms of the separate account contract, income, expenses, gains and losses associated with the assets allocated to a separate account may be credited to or charged against the separate account without regard to other income, expenses, gains, or losses of the insurance company, and the investment results passed through directly to the policyholders. While most, if not all, general account investments are

maintained at book value, separate account investments are normally maintained at market value, which can fluctuate according to market conditions. In large measure, the risks associated with a separate account contract depend on the particular assets in the separate account.

c. The plan's legal rights vary under general and separate account contracts. In general, an insurer is subject to ERISA's fiduciary responsibility provisions with respect to the assets of a separate account (other than a separate account registered under the Investment Company Act of 1940) to the extent that the investment performance of such assets is passed directly through to the plan policyholders. ERISA requires insurers, in administering separate account assets, to act solely in the interest of the plan's participants and beneficiaries; prohibits self-dealing and conflicts of interest; and requires insurers to adhere to a prudent standard of care. In contrast, ERISA generally imposes less stringent standards in the administration of general account contracts which were issued on or before December 31, 1998.

d. On the other hand, State insurance regulation is typically more restrictive with respect to general accounts than separate accounts. However, State insurance regulation may not provide the same level of protection to plan policyholders as ERISA regulation. In addition, insurance company general account policies often include various guarantees under which the insurer assumes risks relating to the funding and distribution of benefits. Insurers do not usually provide any guarantees with respect to the investment returns on assets held in separate accounts. Of course, the extent of any guarantees from any general account or separate account contract will depend upon the specific policy terms.

e. Finally, separate accounts and general accounts pose differing risks in the event of the insurer's insolvency. In the event of insolvency, funds in the general account are available to meet the claims of the insurer's general creditors, after payment of amounts due under certain priority claims, including amounts owed to its policyholders. Funds held in a separate account as reserves for its policy obligations, however, may be protected from the claims of creditors other than the policyholders participating in the separate account. Whether separate account funds will be granted this protection will depend upon the terms of the applicable policies and the provisions of any applicable laws in effect at the time of insolvency.

(e) *Termination procedures.* Within 90 days of written notice by a policyholder to an insurer, the insurer must permit the policyholder to exercise the right to terminate or discontinue the policy and to elect to receive without penalty either:

(1) A lump sum payment representing all unallocated amounts in the accumulation fund. For purposes of this paragraph (e)(1), the term penalty does not include a market value adjustment (as defined in paragraph (h)(7)of this section) or the recovery of costs actually incurred which would have been recovered by the insurer but for the termination or discontinuance of the policy, including any unliquidated acquisition expenses, to the extent not previously recovered by the insurer; or

(2) A book value payment of all unallocated amounts in the accumulation fund under the policy in approximately equal annual installments, over a period of no longer than 10 years, together with interest computed at an annual rate which is no less than the annual rate which was credited to the accumulation fund under the policy as of the date of the contract termination or discontinuance, minus 1 percentage point. Notwithstanding paragraphs (e)(1) and (e)(2) of this section, the insurer may defer, for a period not to exceed 180 days, amounts required to be paid to a policyholder under this paragraph for any period of time during which regular banking activities are suspended by State or federal authorities, a national securities exchange is closed for trading (except for normal holiday closings), or the Securities and Exchange Commission has determined that a state of emergency exists which may make such determination and payment impractical.

(f) *Insurer-initiated amendments*. In the event the insurer makes an insurer-initiated amendment (as defined in paragraph (h)(8) of this section), the insurer must provide written notice to the plan at least 60 days prior to the effective date of the insurer-initiated amendment. The notice must contain a complete description of the amendment and must inform the plan of its right to terminate or discontinue the policy and withdraw all unallocated funds without penalty by sending a written request within such 60 day period to the name and address contained in the notice. The plan must be offered the election to receive either a lump sum or an installment payment as described in paragraph (e)(1) and (e)(2) of this section. An insurer-initiated amendment shall not apply to a contract if the plan fiduciary exercises its right to terminate or discontinue the contract within such 60 day period and to receive a lump sum or installment payment.

(g) *Prudence*. An insurer shall manage those assets of the insurer which are assets of such insurer's general account (irrespective of whether any such assets are plan assets) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, taking into account all obligations supported by such enterprise. This prudence standard applies to the conduct of all insurers with respect to policies issued to plans on or before December 31, 1998, and differs from the prudence standard set forth in section 404(a)(1)(B) of the Act. Under the prudence standard provided in this paragraph, prudence must be determined by reference to all of the obligations supported by the general account, not just the obligations owed to plan policyholders. The more stringent standard of prudence set forth in section 404(a)(1)(B) of the Act continues to apply to any obligations which insurers may have as fiduciaries which do not arise from the management of general account assets, as well as to insurers' management of plan assets maintained in separate accounts. The terms of this section do not modify or reduce the fiduciary obligations applicable to insurers in connection with policies issued after December 31, 1998, which are supported by general account assets, including the standard of prudence under section 404(a)(1)(B) of the Act.

(h) *Definitions*. For purposes of this section:

(1) An *affiliate* of an insurer means:

(i) Any person, directly or indirectly, through one or more intermediaries, controlling, controlled by, or under common control with the insurer,

(ii) Any officer of, director of, 5 percent or more partner in, or highly compensated employee (earning 5 percent or more of the yearly wages of the insurer) of, such insurer or of any person described in paragraph (h)(1)(i) of this section including in the case of an insurer, an insurance agent or broker thereof (whether or not such person is a common law employee) if such agent or broker is an employee described in this paragraph or if the gross income received by such agent or broker from such insurer exceeds 5 percent of such agent's gross income from all sources for the year, and

(iii) Any corporation, partnership, or unincorporated enterprise of which a person described in paragraph (h)(1)(ii) of this section is an officer, director, or a 5 percent or more partner.

(2) The term *control* means the power to exercise a controlling influence over the management or policies of a person other than an individual.

(3) The term *guaranteed benefit policy* means a policy described in section 401(b)(2)(B) of the Act and any regulations promulgated thereunder.

(4) The term *insurer* means an insurer as described in section 401(b)(2)(A) of the Act.

(5) The term *accumulation fund* means the aggregate net considerations (*i.e.*, gross considerations less all deductions from such considerations) credited to the Transition Policy plus all additional amounts, including interest and dividends, credited to such Transition Policy less partial withdrawals, benefit payments and less all charges and fees imposed against this accumulated amount under the Transition Policy other than surrender charges and market value adjustments.

(6) The term *Transition Policy* means:

(i) A policy or contract of insurance (other than a guaranteed benefit policy) that is issued by an insurer to, or on behalf of, an employee benefit plan on or before December 31, 1998, and which is supported by the assets of the insurer's general account.

(ii) A policy will not fail to be a Transition Policy merely because the policy is amended or modified:

(A) To comply with the requirements of section 401(c) of the Act and this section; or

(B) Pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (*e.g.*, shares of stock or policy credits).

(7) For purposes of this section, the term *market value adjustment* means an adjustment to the book value of the accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under the policy. An adjustment is a *market value adjustment* within the meaning of this definition only if the insurer has determined the amount of the adjustment pursuant to a method which was previously disclosed to the policyholder in accordance with paragraph (c)(3)(i)(D) of this section, and the method permits both upward and downward adjustments to the book value of the accumulation fund.

(8) The term *insurer-initiated amendment* is defined in paragraphs (h)(8)(i), (ii) and (iii) of this section as:

(i) An amendment to a Transition Policy made by an insurer pursuant to a unilateral right to amend the policy terms that would have a material adverse effect on the policyholder; or

(ii) Any of the following unilateral changes in the insurer's conduct or practices with respect to the policyholder or the accumulation fund under the policy that result in a material reduction of existing or future benefits under the policy, a material reduction in the value of the policy or a material increase in the cost of financing the plan or plan benefits:

(A) A change in the methodology for assessing fees, expenses, or other charges against the accumulation fund or the policyholder;

(B) A change in the methodology used for allocating income between lines of business, or product classes within a line of business;

(C) A change in the methodology used for determining the rate of return to be credited to the accumulation fund under the policy;

(D) A change in the methodology used for determining the amount of any fees, charges, expenses, or market value adjustments applicable to the accumulation fund under the policy in connection with the termination of the contract or withdrawal from the accumulation fund;

(E) A change in the dividend class to which the policy or contract is assigned;

(F) A change in the policyholder's rights in connection with the termination of the policy, withdrawal of funds or the purchase of annuities for plan participants; and

(G) A change in the annuity purchase rates guaranteed under the terms of the contract or policy, unless the new rates are more favorable for the policyholder.

(iii) For purposes of this definition, an insurer-initiated amendment is material if a prudent fiduciary could reasonably conclude that the amendment should be considered in determining how or whether to exercise any rights with respect to the policy, including termination rights.

(iv) For purposes of this definition, the following amendments or changes are not insurer-initiated amendments:

(A) Any amendment or change which is made with the affirmative consent of the policyholder;

(B) Any amendment or change which is made in order to comply with the requirements of section 401(c) of the Act and this section; or

(C) Any amendment or change which is made pursuant to a merger, acquisition, demutualization, conversion, or

reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (*e.g.*, shares of stock or policy credits).

(i) *Limitation on liability*. (1) No person shall be subject to liability under Parts 1 and 4 of Title I of the Act or section 4975 of the Internal Revenue Code of 1986 for conduct which occurred prior to the applicability dates of the regulation on the basis of a claim that the assets of an insurer (other than plan assets held in a separate account) constitute plan assets. Notwithstanding the provisions of this paragraph (i)(1), this section shall not:

(i) Apply to an action brought by the Secretary of Labor pursuant to paragraphs (2) or (5) of section 502(a) of ERISA for a breach of fiduciary responsibility which would also constitute a violation of Federal or State criminal law;

(ii) Preclude the application of any Federal criminal law; or

(iii) Apply to any civil action commenced before November 7, 1995.

(2) Nothing in this section relieves any person from any State law regulating insurance which imposes additional obligations or duties upon insurers to the extent not inconsistent with the provisions of this section. Therefore, nothing in this section should be construed to preclude a State from requiring insurers to make additional disclosures to policyholders, including plans. Nor does this section prohibit a State from imposing additional substantive requirements with respect to the management of general accounts or from otherwise regulating the relationship between the policyholder and the insurer to the extent not inconsistent with the provisions of this section.

(3) Nothing in this section precludes any claim against an insurer or other person for violations of the Act which do not require a finding that the underlying assets of a general account constitute plan assets, regardless of whether the violation relates to a Transition Policy.

(4) If the requirements in paragraphs (c) through (f) of this section are not met with respect to a plan that has purchased or acquired a Transition Policy, and the insurer has not cured the non-compliance through satisfaction of the requirements in paragraph (i)(5) of this section, the plan's assets include an undivided interest in the underlying assets of the insurer's general account for that period of time for which the requirements are not met. However, an insurer's failure to comply with the requirements of this section with respect to any particular Transition Policy will not result in the underlying assets of the general account constituting plan assets with respect to other Transition Policies if the insurer is otherwise in compliance with the requirements contained in this section.

(5) Notwithstanding paragraphs (a)(2) and (i)(4) of this section, a plan's assets will not include an undivided interest in the underlying assets of the insurer's general account if the insurer made reasonable and good faith attempts at compliance with each of the requirements of paragraphs (c) through (f) of this section, and meets each of the following conditions:

(i) The insurer has in place written procedures that are reasonably designed to assure compliance with the requirements of paragraphs (c) through (f) of this section, including procedures reasonably designed to detect any instances of non-compliance.

(ii) No later than 60 days following the earlier of the insurer's detection of an instance of non-compliance or the receipt of written notice of non-compliance from the plan, the insurer complies with the requirements of paragraphs (c) through (f) of this section. If the insurer has failed to pay a plan the amounts required under paragraphs (e) or (f) of this section within 90 days of receiving written notice of termination or discontinuance of the policy, the insurer must make all corrections and adjustments necessary to restore to the plan the full amounts that the plan would have received but for the insurer's non-compliance within the applicable 60 day period; and

(iii) The insurer makes the plan whole for any losses resulting from the non-compliance as follows:

(A) If the insurer has failed to comply with the disclosure or notice requirements set forth in paragraphs (c), (d) and (f) of this section, then the insurer must make the plan whole for any losses resulting from its non-compliance within the earlier of 60 days of detection by the insurer or sixty days following the receipt of written notice from the plan; and

(B) If the insurer has failed to pay a plan any amounts required under paragraphs (e) or (f) of this section within 90 days of receiving written notice of termination or discontinuance of the policy, the insurer must pay to the plan interest on any amounts restored pursuant to paragraph (i)(5)(ii) of this section at the ''underpayment rate'' as set forth in 26 U.S.C. sections 6621 and 6622. Such interest must be paid within the earlier of 60 days of detection by the insurer or sixty days following receipt of written notice of non-compliance from the plan.

(j) *Applicability dates*. (1) *In general*. Except as provided in paragraphs (j)(2) through (4) of this section, this section is applicable on July 5, 2001.

(2) Paragraph (c) relating to initial disclosures and paragraph (d) relating to separate account disclosures are applicable on July 5, 2000.

(3) The first annual disclosure required under paragraph(c)(4) of this section shall be provided to each plan not later than 18 months following January 5, 2000.

(4) Paragraph (f), relating to insurer-initiated amendments, is applicable on January 5, 2000.

(k) *Effective date*. This section is effective January 5, 2000.

[65 FR 639, Jan. 5, 2000]

§ 2550.403a–1 Establishment of trust.

(a) *In general*. Except as otherwise provided in § 403b–1, all assets of an employee benefit plan shall be held in trust by one or more trustees pursuant to a written trust instrument.

(b) *Specific applications*. (1) The requirements of paragraph (a) of this section will not fail to be satisfied merely because securities of a plan are held in the name of a nominee or in street name, provided such securities are held on behalf of the plan by:

(i) A bank or trust company that is subject to supervision by the United States or a State, or a nominee of such bank or trust company;

(ii) A broker or dealer registered under the Securities Exchange Act of 1934, or a nominee of such broker or dealer; or

(iii) A ''clearing agency,'' as defined in section 3(a)(23) of the Securities Exchange Act of 1934, or its nominee.

(2) Where a corporation described in section 501(c)(2) of the Internal Revenue Code holds property on behalf of a plan, the requirements of paragraph (a) of this section are satisfied with respect to such property if all the stock of such corporation is held in trust on behalf of the plan by one or more trustees.

(3) If the assets of an entity in which a plan invests include plan assets by reason of the plan's investment in the entity, the requirements of paragraph (a) of this section are satisfied with respect to such investment if the indicia of ownership of the plan's interest in the entity are held in trust on behalf of the plan by one or more trustees.

(c) *Requirements concerning trustees*. The trustee or trustees referred to in paragraphs (a) and (b) shall be either named in the trust instrument or in the plan instrument described in section 402(a) of the Act, or appointed by a person who is a named fiduciary (within the meaning of section 402(a)(2) of the Act). Upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control the assets of the plan, except to the extent that:

(1) The plan instrument or the trust instrument expressly provides that the trustee or trustees are subject to the direction of a named fiduciary who is not a trustee, in which case the trustees shall be subject to the proper directions of such fiduciary which are made in accordance with the terms of the plan and which are not contrary to the provisions of title I of the Act of chapter XXV of this title, or

(2) Authority to manage, acquire or dispose of assets of the plan is delegated to one or more investment managers (within the meaning of section 3(38) of the Act) pursuant to section 402(c)(3) of the Act.

[47 FR 21247, May 18, 1982]

§ 2550.403b–1 Exemptions from trust requirement.

(a) *Statutory exemptions.* The requirements of section 403(a) of the Act and section 403a–1 shall not apply—

(1) To any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State;

(2) To any assets of such an insurance company or any assets of a plan which are held by such an insurance company;

(3) To a plan—

(i) Some or all of the participants of which are employees described in section 401(c)(1) of the Internal Revenue Code of 1954; or

(ii) Which consists of one or more individual retirement accounts described in section 408 of the Internal Revenue Code of 1954. To the extent that such plan's assets are held in one or more custodial accounts which qualify under section 401(f) or 408(h) of such Code, whichever is applicable;

(4) To a contract established and maintained under section 403(b) of the Internal Revenue Code of 1954 to the extent that the assets of the contract are held in one or more custodial accounts pursuant to section 403(b)(7) of such Code.

(5) To any plan, fund or program under which an employer, all of whose stock is directly or indirectly owned by employees, former employees or their beneficiaries, proposes through an unfunded arrangement to compensate retired employees for benefits which were forfeited by such employees under a pension plan maintained by a former employer prior to the date such pension plan became subject to the Act.

[47 FR 21247, May 18, 1982]

§ 2550.404a–1 Investment duties.

(a) *In general.* Section 404(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (the Act) provides, in part, that a fiduciary shall discharge his duties with respect to a plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

(b) *Investment duties.* (1) With regard to an investment or investment course of action taken by a fiduciary of an employee benefit plan pursuant to his investmemt duties, the requirements of section 404(a)(1)(B) of the Act set forth in subsection (a) of this section are satisfied if the fiduciary:

(i) Has given appropriate consideration to those facts and circumstances that, given the scope of such fiduciary's investment duties, the fiduciary knows or should know are relevant to the particular investment or investment course of action involved, including the role the investment or investment course of action plays in that portion of the plan's investment portfolio with respect to which the fiduciary has investment duties; and

(ii) Has acted accordingly.

(2) For purposes of paragraph (b)(1) of this section, ''appropriate consideration'' shall include, but is not necessarily limited to,

(i) A determination by the fiduciary that the particular investment or investment course of action is reasonably designed, as part of the portfolio (or, where applicable, that portion of the plan portfolio with respect to which the fiduciary has investment duties), to further the purposes of the plan, taking into consideration the risk of loss and the opportunity for gain (or other return) associated with the investment or investment course of action, and

(ii) Consideration of the following factors as they relate to such portion of the portfolio:

(A) The composition of the portfolio with regard to diversification;

(B) The liquidity and current return of the portfolio relative to the anticipated cash flow requirements of the plan; and

(C) The projected return of the portfolio relative to the funding objectives of the plan.

(3) An investment manager appointed, pursuant to the provisions of section 402(c)(3) of the Act, to manage all or part of the assets of a plan, may, for purposes of compliance with the provisions of paragraphs (b)(1) and (2) of this section, rely on, and act upon the basis of, information pertaining to the plan provided by or at the direction of the appointing fiduciary, if—

(i) Such information is provided for the stated purpose of assisting the manager in the performance of his investment duties, and

(ii) The manager does not know and has no reason to know that the information is incorrect.

(c) *Definitions.* For purposes of this section:

(1) The term *investment duties* means any duties imposed upon, or assumed or undertaken by, a person in connection with the investment of plan assets which make or will make such person a fiduciary of an employee benefit plan or which are performed by such person as a fiduciary of an employee benefit plan as defined in section 3(21)(A)(i) or (ii) of the Act.

(2) The term *investment course of action* means any series or program of investments or actions related to a fiduciary's performance of his investment duties.

(3) The term *plan* means an employee benefit plan to which title I of the Act applies.

[44 FR 37225, June 26, 1979]

§ 2550.404b–1 Maintenance of the indicia of ownership of plan assets outside the jurisdiction of the district courts of the United States.

(a) No fiduciary may maintain the indicia of ownership of any assets of a plan outside the jurisdiction of the district courts of the United States, unless:

(1) Such assets are:

(i) Securities issued by a person, as defined in section 3(9) of the Employee Retirement Income Security Act of 1974 (Act) (other than an individual), which is not organized under the laws of the United States or a State and does not have its principal place of business within the United States;

(ii) Securities issued by a government other than the government of the United States or of a State, or any political subdivision, agency or instrumentality of such a government;

(iii) Securities issued by a person, as defined in section 3(9) of the Act (other than an individual), the principal trading market for which securities is outside the jurisdiction of the district courts of the United States; or

(iv) Currency issued by a government other than the government of the United States if such currency is maintained outside the jurisdiction of the district courts of the United States solely as an incident to the purchase, sale or maintenance of securities described in paragraph (a)(1) of this section; and

(2)(i) Such assets are under the management and control of a fiduciary which is a corporation or partnership organized under the laws of the United States or a State, which fiduciary has its principal place of business within the United States and which is—

(A) A bank as defined in section 202 (a)(2) of the Investment Advisers Act of 1940 that has, as of the last day of its most recent fiscal year, equity capital in excess of $1,000,000;

(B) An insurance company which is qualified under the laws of more than one State to manage, acquire, or dispose of any asset of a plan, which company has, as of the last day of its most recent fiscal year, net worth in excess of $1,000,000 and which is subject to supervision and examination by the State authority having supervision over insurance companies; or

(C) An investment adviser registered under the Investment Advisers Act of 1940 that has, as of the last day of its most recent fiscal year, total client assets under its management and control in excess $50,000,000 and either

(*1*) Shareholders' or partners' equity in excess of $750,000 or

(*2*) All of its obligations and liabilities assumed or guaranteed by a person described in paragraph (a)(2)(i)(A), (B), or (C)(*1*) or (a)(2)(ii)(A)(*2*) of this section; or

(ii) Such indicia of ownership are either

(A) In the physical possession of, or, as a result of normal business operations, are in transit to the physical

possession of, a person which is organized under the laws of the United States or a State, which person has its principal place of business in the United States and which is—

(*1*) A bank as defined in section 202(a)(2) of the Investment Advisers Act of 1940 that has, as of the last day of its most recent fiscal year, equity capital in excess of $1,000,000;

(*2*) A broker or dealer registered under the Securities Exchange Act of 1934 that has, as of the last day of its most recent fiscal year, net worth in excess of $750,000; or

(*3*) A broker or dealer registered under the Securities Exchange Act of 1934 that has all of its obligations and liabilities assumed or guaranteed by a person described in paragraph (a)(2)(i)(A), (B), or (C)(*1*) or (a)(2)(ii)(A)(*2*) of this section; or

(B) Maintained by a broker or dealer, described in paragraph (a)(2)(ii)(A)(*2*) or (*3*) of this section, in the custody of an entity designated by the Securities and Exchange Commission as a ''satisfactory control location'' with respect to such broker or dealer pursuant to Rule 15c3–3 under the Securities Exchange Act of 1934, provided that:

(*1*) Such entity holds the indicia of ownership as agent for the broker or dealer, and

(*2*) Such broker or dealer is liable to the plan to the same extent it would be if it retained the physical possession of the indicia of ownership pursuant to paragraph (a)(2)(ii)(A) of this section.

(C) Maintained by a bank described in paragraph (a)(2)(ii)(A)(*1*), in the custody of an entity that is a foreign securities depository, foreign clearing agency which acts as a securities depository, or foreign bank, which entity is supervised or regulated by a government agency or regulatory authority in the foreign jurisdiction having authority over such depositories, clearing agencies or banks, provided that:

(*1*) The foreign entity holds the indicia of ownership as agent for the bank;

(*2*) The bank is liable to the plan to the same extent it would be if it retained the physical possession of the indicia of ownership within the United States;

(*3*) The indicia of ownership are not subject to any right, charge, security interest, lien or claim of any kind in favor of the foreign entity except for their safe custody or administration;

(*4*) Beneficial ownership of the assets represented by the indicia of ownership is freely transferable without the payment of money or value other than for safe custody or administration; and

(*5*) Upon request by the plan fiduciary who is responsible for the selection and retention of the bank, the bank identifies to such fiduciary the name, address and principal place of business of the foreign entity which acts as custodian for the plan pursuant to this paragraph (a)(2)(ii)(C), and the name and address of the governmental agency or other regulatory authority that supervises or regulates that foreign entity.

(b) Notwithstanding any requirement of paragraph (a) of this section, a fiduciary with respect to a plan may maintain in Canada the indicia of ownership of plan assets which are attributable to a contribution made on behalf of a plan participant who is a citizen or resident of Canada, if such indicia of ownership must remain in Canada in order for the plan to qualify for and maintain tax exempt status under the laws of Canada or to comply with other applicable laws of Canada or any Province of Canada.

(c) For purposes of this regulation:

(1) The term *management and control* means the power to direct the acquisition or disposition through purchase, sale, pledging, or other means; and

(2) The term *depository* means any company, or agency or instrumentality of government, that acts as a custodian of securities in connection with a system for the central handling of securities whereby all securities of a particular class or series of any issuer deposited within the system are treated as fungible and may be transferred, loaned, or pledged by bookkeeping entry without physical delivery of securities certificates.

[42 FR 54124, Oct. 4, 1977, as amended at 46 FR 1267, Jan. 6, 1981]

§ 2550.404c–1 ERISA section 404(c) plans.

(a) *In general.* (1) Section 404(c) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) provides

that if a pension plan that provides for individual accounts permits a participant or beneficiary to exercise control over assets in his account and that participant or beneficiary in fact exercises control over assets in his account, then the participant or beneficiary shall not be deemed to be a fiduciary by reason of his exercise of control and no person who is otherwise a fiduciary shall be liable for any loss, or by reason of any breach, which results from such exercise of control. This section describes the kinds of plans that are ''ERISA section 404(c) plans,'' the circumstances in which a participant or beneficiary is considered to have exercised independent control over the assets in his account as contemplated by section 404(c), and the consequences of a participant's or beneficiary's exercise of control.

(2) The standards set forth in this section are applicable solely for the purpose of determining whether a plan is an ERISA section 404(c) plan and whether a particular transaction engaged in by a participant or beneficiary of such plan is afforded relief by section 404(c). Such standards, therefore, are not intended to be applied in determining whether, or to what extent, a plan which does not meet the requirements for an ERISA section 404(c) plan or a fiduciary with respect to such a plan satisfies the fiduciary responsibility or other provisions of title I of the Act.

(b) *ERISA section 404(c) plans*—(1) *In general*. An ''ERISA section 404(c) Plan'' is an individual account plan described in section 3(34) of the Act that:

(i) Provides an opportunity for a participant or beneficiary to exercise control over assets in his individual account (see paragraph (b)(2) of this section); and

(ii) Provides a participant or beneficiary an opportunity to choose, from a broad range of investment alternatives, the manner in which some or all of the assets in his account are invested (see paragraph (b)(3) of this section).

(2) *Opportunity to exercise control*. (i) a plan provides a participant or beneficiary an opportunity to exercise control over assets in his account only if:

(A) Under the terms of the plan, the participant or beneficiary has a reasonable opportunity to give investment instructions (in writing or otherwise, with opportunity to obtain written confirmation of such instructions) to an identified plan fiduciary who is obligated to comply with such instructions except as otherwise provided in paragraph (b)(2)(ii)(B) and (d)(2)(ii) of this section; and

(B) The participant or beneficiary is provided or has the opportunity to obtain sufficient information to make informed decisions with regard to investment alternatives available under the plan, and incidents of ownership appurtenant to such investments. For purposes of this subparagraph, a participant or beneficiary will not be considered to have sufficient investment information unless—

(*I*) The participant or beneficiary is provided by an identified plan fiduciary (or a person or persons designated by the plan fiduciary to act on his behalf):

(*i*) An explanation that the plan is intended to constitute a plan described in section 404(c) of the Employee Retirement Income Security Act, and title 29 of the Code of Federal Regulations, § 2550.440c–1, and that the fiduciaries of the plan may be relieved of liability for any losses which are the direct and necessary result of investment instructions given by such participant or beneficiary;

(*ii*) A description of the investment alternatives available under the plan and, with respect to each designated investment alternative, a general description of the investment objectives and risk and return characteristics of each such alternative, including information relating to the type and diversification of assets comprising the portfolio of the designed investment alternative;

(*iii*) Identification of any designated investment managers;

(*iv*) An explanation of the circumstances under which participants and beneficiaries may give investment instructions and explanation of any specified limitations on such instructions under the terms of the plan, including any restrictions on transfer to

or from a designated investment alternative, and any restrictions on the exercise of voting, tender and similar rights appurtenant to a participant's or beneficiary's investment in an investment alternative;

(*v*) A description of any transaction fees and expenses which affect the participant's or beneficiary's account balance in connection with purchases or sales of interests in investment alternatives (e.g., commissions, sales load, deferred sales charges, redemption or exchange fees);

(*vi*) The name, address, and phone number of the plan fiduciary (and, if applicable, the person or persons designated by the plan fiduciary to act on his behalf) responsible for providing the information described in paragraph (b)(2)(i)(B)(*2*) upon request of a participant or beneficiary and a description of the information described in paragraph (b)(2)(i)(B)(*2*) which may be obtained on request;

(*vii*) In the case of plans which offer an investment alternative which is designed to permit a participant or beneficiary to directly or indirectly acquire or sell any employer security (employer security alternative), a description of the procedures established to provide for the confidentiality of information relating to the purchase, holding and sale of employer securities, and the exercise of voting, tender and similar rights, by participants and beneficiaries, and the name, address and phone number of the plan fiduciary responsible for monitoring compliance with the procedures (see paragraphs (d)(2)(ii)(E)(*4*)(*vii*), (*viii*) and (*ix*) of this section); and

(*viii*) In the case of an investment alternative which is subject to the Securities Act of 1933, and in which the participant or beneficiary has no assets invested, immediately following the participant's or beneficiary's initial investment, a copy of the most recent prospectus provided to the plan. This condition will be deemed satisfied if the participant or beneficiary has been provided with a copy of such most recent prospectus immediately prior to the participant's or beneficiary's initial investment in such alternative;

(*ix*) Subsequent to an investment in a investment alternative, any materials provided to the plan relating to the exercise of voting, tender or similar rights which are incidental to the holding in the account of the participant or beneficiary of an ownership interest in such alternative to the extent that such rights are passed through to participants and beneficiaries under the terms of the plan, as well as a description of or reference to plan provisions relating to the exercise of voting, tender or similar rights.

(*2*) The participants or beneficiary is provided by the identified plan fiduciary (or a person or persons designated by the plan fiduciary to act on his behalf), either directly or upon request, the following information, which shall be based on the latest information available to the plan:

(*i*) A description of the annual operating expenses of each designated investment alternative (e.g., investment management fees, administrative fees, transaction costs) which reduce the rate of return to participants and beneficiaries, and the aggregate amount of such expenses expressed as a percentage of average net assets of the designated investment alternative;

(*ii*) Copies of any prospectuses, financial statements and reports, and of any other materials relating to the investment alternatives available under the plan, to the extent such information is provided to the plan;

(*iii*) A list of the assets comprising the portfolio of each designated investment altenaive which constitute plan assets within the meaning of 29 CFR 2510.3–101, the value of each such asset (or the proportion of the investment alternative which it comprises), and, with respect to each such asset which is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term of the contract and the rate of return on the contract;

(*iv*) Information concerning the value of shares or units in designated investment alternatives available to participants and beneficiaries under the plan, as well as the past and current investment performance of such alternatives, determined, net of expenses, on a reasonable and consistent basis; and

(*v*) Information concerning the value of shares or units in designated investment alternatives held in the account of the participant or beneficiary.

(ii) A plan does not fail to provide an opportunity for a participant or beneficiary to exercise control over his individual account merely because it—

(A) *Imposes charges for reasonable expenses.* A plan may charge participants' and beneficiaries' accounts for the reasonable expenses of carrying out investment instructions, provided that procedures are established under the plan to periodically inform such participants and beneficiaries of actual expenses incurred with respect to their respective individual accounts;

(B) *Permits a fiduciary to decline to implement investment instructions by participants and beneficiaries.* A fiduciary may decline to implement participant and beneficiary instructions which are described at paragraph (d)(2)(ii) of this section, as well as instructions specified in the plan, including instructions—

(*1*) Which would result in a prohibited transaction described in ERISA section 406 or section 4975 of the Internal Revenue Code, and

(*2*) Which would generate income that would be taxable to the plan;

(C) *Imposes reasonable restrictions on frequency of investment instructions.* A plan may impose reasonable restrictions on the frequency with which participants and beneficiaries may give investment instructions. In no event, however, is such a restriction reasonable unless, with respect to each investment alternative made available by the plan, it permits participants and beneficiaries to give investment instructions with a frequency which is appropriate in light of the market volatility to which the investment alternative may reasonably be expected to be subject, provided that—

(*1*) At least three of the investment alternatives made available pursuant to the requirements of paragraph (b)(3)(i)(B) of this section, which constitute a broad range of investment alternatives, Permit participants and beneficiaries to give investment instructions no less frequently than once within any three month period; and

(*2*)(*i*) At least one of the investment alternatives meeting the requirements of paragraph (b)(2)(ii)(C)(*1*) of this section permits participants and beneficiaries to give investment instructions with regard to transfers into the investment alternative as frequently as participants and beneficiaries are permitted to give investment instructions with respect to any investment alternative made available by the plan which permits participants and beneficiaries to give investment instructions more frequently than once within any three month period; or

(*ii*) With respect to each investment alternative which permits participants and beneficiaries to give investment instructions more frequently than once within any three month period, participants and beneficiaries are permitted to direct their investments from such alternative into an income producing, low risk, liquid fund, subfund, or account as frequently as they are permitted to give investment instructions with respect to each such alternative and, with respect to such fund, subfund or account, participants and beneficiaries are permitted to direct investments from the fund, subfund or account to an investment alternative meeting the requirements of paragraph (b)(2)(ii)(C)(*1*) as frequently as they are permitted to give investment instructions with respect to that investment alternative; and

(*3*) With respect to transfers from an investment alternative which is designed to permit a participant or beneficiary to directly or indirectly acquire or sell any employer security (employer security alternative) either:

(*i*) All of the investment alternatives meeting the requirements of paragraph (b)(2)(ii)(C)(*1*) of this section must permit participants and beneficiaries to give investment instructions with regard to transfers into each of the investment alternatives as frequently as participants and beneficiaries are permitted to give investment instructions with respect to the employer security alternative; or

(*ii*) Participants and beneficiaries are permitted to direct their investments from each employer security alternative into an income producing, low risk, liquid fund, subfund, or account

as frequently as they are permitted to give investment instructions with respect to such employer security alternative and, with respect to such fund, subfund, or account, participants and beneficiaries are permitted to direct investments from the fund, subfund or account to each investment alternative meeting the requirements of paragraph (b)(2)(ii)(C)(*1*) as frequently as they are permitted to give investment instructions with respect to each such investment alternative.

(iii) Paragraph (c) of this section describes the circumstances under which a participant or beneficiary will be considered to have exercised independent control with respect to a particular transaction.

(3) *Broad range of investment alternatives.* (i) A plan offers a broad range of investment alternatives only if the available investment alternatives are sufficient to provide the participant or beneficiary with a reasonable opportunity to:

(A) Materially affect the potential return on amounts in his individual account with respect to which he is permitted to exercise control and the degree of risk to which such amounts are subject;

(B) Choose from at least three investment alternatives:

(*1*) Each of which is diversified;

(*2*) Each of which has materially different risk and return characteristics;

(*3*) Which in the aggregate enable the participant or beneficiary by choosing among them to achieve a portfolio with aggregate risk and return characteristics at any point within the range normally appropriate for the participant or beneficiary; and

(*4*) Each of which when combined with investments in the other alternatives tends to minimize through diversification the overall risk of a participant's or beneficiary's portfolio;

(C) Diversify the investment of that portion of his individual account with respect to which he is permitted to exercise control so as to minimize the risk of large losses, taking into account the nature of the plan and the size of participants' or beneficiaries' accounts. In determining whether a plan provides the participant or beneficiary with a reasonable opportunity to diversify his investments, the nature of the investment alternatives offered by the plan and the size of the portion of the individual's account over which he is permitted to exercise control must be considered. Where such portion of the account of any participant or beneficiary is so limited in size that the opportunity to invest in look-through investment vehicles is the only prudent means to assure an opportunity to achieve appropriate diversification, a plan may satisfy the requirements of this paragraph only by offering look-through investment vehicles.

(ii) *Diversification and look-through investment vehicles.* Where look-through investment vehicles are available as investment alternatives to participants and beneficiaries, the underlying investments of the look-through investment vehicles shall be considered in determining whether the plan satisfies the requirements of subparagraphs (b)(3)(i)(B) and (b)(3)(i)(C).

(c) *Exercise of control*—(1) *In general.* (i) Sections 404(c)(1) and 404(c)(2) of the Act and paragraphs (a) and (d) of this section apply only with respect to a transaction where a participant or beneficiary has exercised independent control in fact with respect to the investment of assets in his individual account under an ERISA section 404(c) plan.

(ii) For purposes of sections 404(c)(1) and 4040(c)(2) of the Act and paragraphs (a) and (d) of this section, a participant or beneficiary will be deemed to have exercised control with respect to the exercise of voting, tender and similar rights appurtenant to the participant's or beneficiary's ownership interest in an investment alternative, provided that the participant's or beneficiary's investment in the investment alternative was itself the result of an exercise of control, the participant or beneficiary was provided a reasonable opportunity to give instruction with respect to such incidents of ownership, including the provision of the information described in paragraph (b)(2)(i)(B)(*1*)(*ix*) of this section, and the participant or beneficiary has not failed to exercise control by reason of

the circumstances described in paragraph (c)(2) with respect to such incidents of ownership.

(2) *Independent control.* Whether a participant or beneficiary has exercised independent control in fact with respect to a transaction depends on the facts and circumstances of the particular case. However, a participant's or beneficiary's exercise of control is not independent in fact if:

(i) The participant or beneficiary is subjected to improper influence by a plan fiduciary or the plan sponsor with respect to the transaction;

(ii) A plan fiduciary has concealed material non-public facts regarding the investment from the participant or beneficiary, unless the disclosure of such information by the plan fiduciary to the participant or beneficiary would violate any provision of federal law or any provision of state law which is not preempted by the Act; or

(iii) The participant or beneficiary is legally incompetent and the responsible plan fiduciary accepts the instructions of the participant or beneficiary knowing him to be legally incompetent.

(3) *Transactions involving a fiduciary.* In the case of a sale, exchange or leasing of property (other than a transaction described in paragraph (d)(2)(ii)(E) of this section) between an ERISA section 404(c) plan and a plan fiduciary or an affiliate of such a fiduciary, or a loan to a plan fiduciary or an affiliate of such a fiduciary, the participant or beneficiary will not be deemed to have exercised independent control unless the transaction is fair and reasonable to him. For purposes of this paragraph (c)(3), a transaction will be deemed to be fair and reasonable to a participant or beneficiary if he pays no more than, or receives no less than, adequate consideration (as defined in section 3(18) of the Act) in connection with the transaction.

(4) *No obligation to advise.* A fiduciary has no obligation under part 4 of title I of the Act to provide investment advice to a participant or beneficiary under an ERISA section 404(c) plan.

(d) *Effect of independent exercise of control*—(1) *Participant or beneficiary not a fiduciary.* If a participant or beneficiary of an ERISA section 404(c) plan exercises independent control over assets in his individual account in the manner described in paragraph (c), then such participant or beneficiary is not a fiduciary of the plan by reason of such exercise of control.

(2) *Limitation on liability of plan fiduciaries.* (i) If a participant or beneficiary of an ERISA section 404(c) plan exercises independent control over assets in his individual account in the manner described in paragraph (c), then no other person who is a fiduciary with respect to such plan shall be liable for any loss, or with respect to any breach of part 4 of title I of the Act, that is the direct and necessary result of that participant's or beneficiary's exercise of control.

(ii) Paragraph (d)(2)(i) does not apply with respect to any instruction, which if implemented—

(A) Would not be in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of title I of ERISA;

(B) Would cause a fiduciary to maintain the indicia of ownership of any assets of the plan outside the jurisdiction of the district courts of the United States other than as permitted by section 404(b) of the Act and 29 CFR 2550.404b–1;

(C) Would jeopardize the plan's tax qualified status under the Internal Revenue Code;

(D) Could result in a loss in excess of a participant's or beneficiary's account balance; or

(E) Would result in a direct or indirect:

(*1*) Sale, exchange, or lease of property between a plan sponsor or any affiliate of the sponsor and the plan except for the acquisition or disposition of any interest in a fund, subfund or portfolio managed by a plan sponsor or an affiliate of the sponsor, or the purchase or sale of any qualifying employer security (as defined in section 407(d)(5) of the Act) which meets the conditions of section 408(e) of ERISA and section (d)(2)(ii)(E)(*4*) below;

(*2*) Loan to a plan sponsor or any affiliate of the sponsor;

(*3*) Acquisition or sale of any employer real property (as defined in section 407(d)(2) of the Act); or

(*4*) Acquisition or sale of any employer security except to the extent that:

(*i*) Such securities are qualifying employer securities (as defined in section 407(d)(5) of the Act);

(*ii*) Such securities are stock or an equity interest in a publicly traded partnership (as defined in section 7704(b) of the Internal Revenue Code of 1986), but only if such partnership is an existing partnership as defined in section 10211(c)(2)(A) of the Revenue Act of 1987 (Public Law 100–203);

(*iii*) Such securities are publicly traded on a national exchange or other generally recognized market;

(*iv*) Such securities are traded with sufficient frequency and in sufficient volume to assure that participant and beneficiary directions to buy or sell the security may be acted upon promptly and efficiently;

(*v*) Information provided to shareholders of such securities is provided to participants and beneficiaries with accounts holding such securities;

(*vi*) Voting, tender and similar rights with respect to such securities are passed through to participants and beneficiaries with accounts holding such securities;

(*vii*) Information relating to the purchase, holding, and sale of securities, and the exercise of voting, tender and similar rights with respect to such securities by participants and beneficiaries, is maintained in accordance with procedures which are designed to safeguard the confidentiality of such information, except to the extent necessary to comply with Federal laws or state laws not preempted by the Act;

(*viii*) The plan designates a fiduciary who is responsible for ensuring that: The procedures required under subparagraph (d)(2)(ii)(E)(*4*)(*vii*) are sufficient to safeguard the confidentiality of the information described in that subparagraph, such procedures are being followed, and the independent fiduciary required by subparagraph (d)(2)(ii)(E)(*4*)(*ix*) is appointed; and

(*ix*) An independent fiduciary is appointed to carry out activities relating to any situations which the fiduciary designated by the plan for purposes of subparagraph (d)(2)(ii)(E)(*4*)(*viii*) determines involve a potential for undue employer influence upon participants and beneficiaries with regard to the direct or indirect exercise of shareholder rights. For purposes of this subparagraph, a fiduciary is not independent if the fiduciary is affiliated with any sponsor of the plan.

(iii) The individual investment decisions of an investment manager who is designated directly by a participant or beneficiary or who manages a look-through investment vehicle in which a participant or beneficiary has invested are not direct and necessary results of the designation of the investment manager or of investment in the look-through investment vehicle. However, this paragraph (d)(2)(iii) shall not be construed to result in liability under section 405 of ERISA with respect to a fiduciary (other than the investment manager) who would otherwise be relieved of liability by reason of section 404(c)(2) of the Act and paragraph (d) of this section.

(3) *Prohibited transactions.* The relief provided by section 404(c) of the Act and this section applies only to the provisions of part 4 of title I of the Act. Therefore, nothing in this section relieves a disqualified person from the taxes imposed by sections 4975 (a) and (b) of the Internal Revenue Code with respect to the transactions prohibited by section 4975(c)(1) of the Code.

(e) *Defintions.* For purposes of this section:

(1) *Look-through investment vehicle* means:

(i) An investment company described in section 3(a) of the Investment Company Act of 1940, or a series investment company described in section 18(f) of the 1940 Act or any of the segregated portfolios of such company;

(ii) A common or collective trust fund or a pooled investment fund maintained by a bank or similar institution, a deposit in a bank or similar institution, or a fixed rate investment contract of a bank or similar institution;

(iii) A pooled separate account or a fixed rate investment contract of an insurance company qualified to do business in a State; or

(iv) Any entity whose assets include plan assets by reason of a plan's investment in the entity;

(2) *Adequate consideration* has the meaning given it in section 3(18) of the Act and in any regulations under this title;

(3) An *affiliate* of a person includes the following:

(i) Any person directly or indirectly controlling, controlled by, or under common control with the person;

(ii) Any officer, director, partner, employee, an employee of an affiliated employer, relative (as defined in section 3(15) of ERISA), brother, sister, or spouse of a brother or sister, of the person; and

(iii) Any corporation or partnership of which the person is an officer director or partner.

For purposes of this paragraph (e)(3), the term ''control'' means, with respect to a person other than an individual, the power to exercise a controlling influence over the management or policies of such person.

(4) A *designated investment alternative* is a specific investment identified by a plan fiduciary as an available investment alternative under the plan.

(f) *Examples*. The provisions of this section are illustrated by the following examples. Examples (5) through (11) assume that the participant has exercised independent control with respect to his individual account under an ERISA section 404(c) plan described in paragraph (b) and has not directed a transaction described in paragraph (d)(2)(ii).

(1) Plan A is an individual account plan described in section 3(34) of the Act. The plan states that a plan participant or beneficiary may direct the plan administrator to invest any portion of his individual account in a particular diversified equity fund managed by an entity which is not affiliated with the plan sponsor, or any other asset administratively feasible for the plan to hold. However, the plan provides that the plan administrator will not implement certain listed instructions for which plan fiduciaries would not be relieved of liability under section 404(c) (see paragraph (d)(2)(ii)). Plan participants and beneficiaries are permitted to give investment instructions during the first week of each month with respect to the equity fund and at any time with respect to other investments. The plan provides for the pass-through of voting, tender and similar rights incidental to the holding in the account of a participant or beneficiary of an ownership interest in the equity fund or any other investment alternative available under the plan. The plan administrator of plan A provides each participant and beneficiary with the information described in subparagraphs (*i*), (*ii*), (*iii*), (*iv*), (*v*), (*vi*) and (*vii*) of paragraph (b)(2)(i)(B)(*1*) upon their entry into the plan, and provides updated information in the event of any material change in the information provided. Immediately following an investment by a participant or beneficiary in the equity fund, the plan administrator provides a copy of the most recent prospectus received from the fund to the investing participant or beneficiary. Immediately following any investment by a participant or beneficiary in any other investment alternative which is subject to the Securities Act of 1933, the plan administrator provides the participant or beneficiary with the most recent prospectus received from that investment alternative (see paragraph (b)(2)(i)(B)(*1*)(*viii*)). Finally, subsequent to any investment by a participant or beneficiary, the plan administrator forwards to the investing participant or beneficiary any materials provided to the plan relating to the exercise of voting, tender or similar rights attendant to ownership of an interest in such investment (see paragraph (b)(2)(i)(B)(*1*)(*ix*)). Upon request, the plan administrator provides each participant or beneficiary with copies of any prospectuses, financial statements and reports, and any other materials relating to the investment alternatives available under the plan which are received by the plan (see paragraph (b)(2)(i)(B)(*2*)(*ii*)). Also upon request, the plan administrator provides each participant and beneficiary with the other information required by paragraph (b)(2)(i)(B)(*2*) with respect to the equity fund, which is a designated investment alternative, including information concerning the latest available value of the participant's or beneficiary's interest in the equity fund (see paragraph (b)(2)(i)(B)(*2*)(*v*)). Plan A meets the requirements of paragraphs (b)(2)(i)(B)(*1*) and (*2*) of this section regarding the provision of investment information.

NOTE: The regulation imposes no additional obligation on the administrator to furnish or make available materials relating to the companies in which the equity fund invests (e.g., prospectuses, proxies, etc.).

(2) Plan C is an individual account plan described in section 3(34) of the Act under which participants and beneficiaries may choose among three investment alternatives which otherwise meet the requirements of paragraph (b) of this section. The plan permits investment instruction with respect to each investment alternative only on the first 10 days of each calendar quarter, i.e. January 1–10, April 1–10, July 1–10 and October 1–10. Plan C satisfies the condition of paragraph (b)(2)(ii)(C)(*1*) that instruction be permitted not less frequently than once within any

three month period, since there is not any three month period during which control could not be exercised.

(3) Assume the same facts as in paragraph (f)(2), except that investment instruction may only be given on January 1, April 4, July 1 and October 1. Plan C is not an ERISA section 404(c) plan because it does not satisfy the condition of paragraph (b)(2)(ii)(C)(*1*) that instruction be permitted not less frequently than once within any three month period. Under these facts, there is a three month period, e.g., January 2 through April 1, during which control could not be exercised by participants and beneficiaries.

(4) Plan D is an individual account plan described in section 3(34) of the Act under which participants and beneficiaries may choose among three diversified investment alternatives which constitute a broad range of investment alternatives. The plan also permits investment instruction with respect to an employer securities alternative but provides that a participant or beneficiary can invest no more than 25% of his account balance in this alternative. This restriction does not affect the availability of relief under section 404(c) inasmuch as it does not relate to the three diversified investment alternatives and, therefore, does not cause the plan to fail to provide an opportunity to choose from a broad range of investment alternatives.

(5) A participant, P, independently exercises control over assets in his individual account plan by directing a plan fiduciary, F, to invest 100% of his account balance in a single stock. P is not a fiduciary with respect to the plan by reason of his exercise of control and F will not be liable for any losses that necessarily result form P's investment instruction.

(6) Assume the same facts as in paragraph (f)(5), except that P directs F to purchase the stock from B, who is a party in interest with respect to the plan. Neither P nor F has engaged in a transaction prohibited under section 406 of the Act: P because he is not a fiduciary with respect to the plan by reason of his exercise of control and F because he is not liable for any breach of part 4 of title I that is the direct and necessary consequence of P's exercise of control. However, a prohibited transaction under section 4975(c) of the Internal Revenue Code may have occurred, and, in the absence of an exemption, tax liability may be imposed pursuant to sections 495 (a) and (b) of the Code.

(7) Assume the same facts as in paragraph (f)(5), except that P does not specify that the stock be purchased from B, and F chooses to purchase the stock from B. In the absence of an exemption, F has engaged in a prohibited transaction described in 406(a) of ERISA because the decision to purchase the stock from B is not a direct or necessary result of P's exercise of control.

(8) Pursuant to the terms of the plan, plan fiduciary F designates three reputable investment managers whom participants may appoint to manage assets in their individual accounts. Participant P selects M, one of the designated managers, to manage the assets in his account. M prudently manages P's account for 6 months after which he incurs losses in managing the account through his imprudence. M has engaged in a breach of fiduciary duty because M's imprudent management of P's account is not a direct or necessary result of P's exercise of control (the choice of M as manager). F has no fiduciary liability for M's imprudence because he has no affirmative duty to advise P (see paragraph (c)(4)) and because F is relieved of co-fiduciary liability by reason of section 404(c)(2) (see paragraph (d)(2)(iii)). F does have a duty to monitor M's performance to determine the suitability of continuing M as an investment manager, however, and M's imprudence would be a factor which F must consider in periodically reevaluating its decision to designate M.

(9) Participant P instructs plan fiduciary F to appoint G as his investment manager pursuant to the terms of the plan which provide P total discretion in choosing an investment manager. Through G's imprudence, G incurs losses in managing P's account. G has engaged in a breach of fiduciary duty because G's imprudent management of P's account is not a direct or necessary result of P's exercise of control (the choice of G as manager). Plan fiduciary F has no fiduciary liability for G's imprudence because F has no obligation to advise P (see paragraph (c)(4)) and because F is relieved of co-fiduciary liability for G's actions by reason of section 404(c)(2) (see paragraph (d)(2)(iii)). In addition, F also has no duty to determine the suitability of G as an investment manager because the plan does not designate G as an investment manager.

(10) Participant P directs a plan fiduciary, F, a bank, to invest all of the assets in his individual account in a collective trust fund managed by F that is designed to be invested solely in a diversified portfolio of common stocks. Due to economic conditions, the value of the common stocks in the bank collective trust fund declines while the value of publicly-offered fixed income obligations remains relatively stable. F is not liable for any losses incurred by P solely because his individual account was not diversified to include fixed income obligations. Such losses are the direct result of P's exercise of control; moreover, under paragraph (c)(4) of this section F has no obligation to advise P regarding his investment decisions.

(11) Assume the same facts as in paragraph (f)(10) except that F, in managing the collective trust fund, invests the assets of the fund solely in a few highly speculative stocks. F

is liable for losses resulting from its imprudent investment in the speculative stocks and for its failure to diversify the assets of the account. This conduct involves a separate breach of F's fiduciary duty that is not a direct or necessary result of P's exercise of control (see paragraph (d)(2)(iii)).

(g) *Effective date*—(1) *In general.* Except as provided in paragraph (g)(2), this section is effective with respect to transactions occurring on or after the first day of the second plan year beginning on or after October 13, 1992.

(2) This section is effective with respect to transactions occurring under a plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before October 13, 1992 after the later of the date determined under paragraph (g)(1) or the date on which the last collective bargaining agreement terminates. For purposes of this paragraph (g)(2), any extension or renegotiation of a collective bargaining agreement which is ratified on or after October 13, 1992 is to be disregarded in determining the date on which the agreement terminates.

(3) Transactions occurring before the date determined under subparagraph (g)(1) or (2) of this section, as applicable, are governed by section 404(c) of the Act without regard to the regulation.

[57 FR 46932, Oct. 13, 1992]

§ 2550.407a–1 General rule for the acquisition and holding of employer securities and employer real property.

(a) *In general.* Section 407(a)(1) of the Employee Retirement Income Security Act of 1974 (the Act) states that except as otherwise provided in section 407 and section 414 of the Act, a plan may not acquire or hold any employer security which is not a qualifying employer security or any employer real property which is not qualifying employer real property. Section 406(a)(1)(E) prohibits a fiduciary from knowingly causing a plan to engage in a transaction which constitutes a direct or indirect acquisition, on behalf of a plan, of any employer security or employer real property in violation of section 407(a), and section 406(a)(2) prohibits a fiduciary who has authority or discretion to control or manage assets of a plan to permit the plan to hold any employer security or employer real property if he knows or should know that holding such security or real property violates section 407(a).

(b) *Requirements applicable to all plans.* A plan may hold or acquire only employer securities which are qualifying employer securities and employer real property which is qualifying employer real property. A plan may not hold employer securities and employer real property which are not qualifying employer securities and qualifying employer real property, except to the extent that:

(1) The employer security is held by a plan which has made an election under section 407(c)(3) of the Act; or

(2) The employer security is a loan or other extension of credit which satisfies the requirements of section 414(c)(1) of the Act or the employer real property is leased to the employer pursuant to a lease which satisfies the requirements of section 414(c)(2) of the Act.

[42 FR 47201, Sept. 20, 1977; 42 FR 59842, Nov. 22, 1977]

§ 2550.407a–2 Limitation with respect to the acquisition of qualifying employer securities and qualifying employer real property.

(a) *In general.* Section 407(a)(2) of the Employee Retirement Income Security Act of 1974 (the Act) provides that a plan may not acquire any qualifying employer security or qualifying employer real property, if immediately after such acquisition the aggregate fair market value of qualifying employer securities and qualifying employer real property held by the plan exceeds 10 percent of the fair market value of the assets of the plan.

(b) *Acquisition.* For pusposes of section 407(a) of the Act, an acquisition by a plan of qualifying employer securities or qualifying employer real property shall include, but not be limited to, an acquisition by purchase, by the exchange of plan assets, by the exercise of warrants or rights, by the conversion of a security (except any acquisition pursuant to a conversion exempt under section 408(b)(7) of the Act), by

default of a loan where the qualifying employer security or qualifying employer real property was security for the loan, or by the contribution of such securities or real property to the plan. However, an acquisition of a security shall not be deemed to have occured if a plan acquires the security as a result of a stock dividend or stock split.

(c) *Fair market value—Indebtedness incurred in connection with the acquisition of a plan asset*. In determining whether a plan is in compliance with the limitation on the acquisition of qualifying employer securities and qualifying employer real property in section 407(a)(2), the limitation on the holding of qualifying employer securities and qualifying employer real property in section 407(a)(3) and § 2550.407a–3 thereunder, and the requirement regarding the disposition of employer securities and employer real property in section 407(a)(4) and § 2550.407a–4 thereunder, the fair market value of total plan assets shall be the fair market value of such assets less the unpaid amount of:

(1) Any indebtedness incurred by the plan in acquiring such assets;

(2) Any indebtedness incurred before the acquisition of such assets if such indebtedness would not have been incurred but for such acquisition; and

(3) Any indebtedness incurred after the acquisition of such assets if such indebtedness would not have been incurred but for such acquisition and the incurrence of such indebtedness was reasonably foreseeable at the time of such acquisition. However, the fair market value of qualifying employer securities and qualifying employer real property shall be the fair market value of such assets without any reduction for the unpaid amount of any indebtedness incurred by the plan in connection with the acquisition of such employer securities and employer real property.

(d) *Examples*. (1) Plan assets have a fair market value of $100,000. The plan has no liabilities other than liabilities for vested benefits of participants and does not own any employer securities or employer real property. The plan proposes to acquire qualifying employer securities with a fair market value of $10,000 by paying $1,000 in cash and borrowing $9,000. The fair market value of plan assets would be $100,000 ($100,000 of plan assets less $1,000 cash payment plus $10,000 of employer securities less $9,000 indebtedness), the fair market value of the qualifying employer securities would be $10,000, which is 10 percent of the fair market value of plan assets. Accordingly, the acquisition would not contravene section 407(a).

(2) Plan assets have a fair market value of $100,000. The plan has liabilities of $20,000 which were incurred in connection with the acquisition of those assets, and does not own any employer securities or employer real property. The plan proposes to pay cash for qualifying employer securities with a fair market value of $10,000. The fair market value of plan assets would be $80,000 ($100,000 of plan assets less $10,000 cash payment plus $10,000 of employer securities less $20,000 indebtedness), the fair market value of the qualifying employer securities would be $10,000, which is 12.5 percent of the fair market value of plan assets. Accordingly, the acquisition would contravene section 407(a).

[42 FR 47201, Sept. 20, 1977]

§ 2550.407d–5 Definition of the term "qualifying employer security".

(a) *In general*. For purposes of this section and section 407(d)(5) of the Employee Retirement Income Security Act of 1974 (the Act), the term ''qualifying employer security'' means an employer security which is:

(1) Stock; or

(2) A marketable obligation, as defined in paragraph (b) of this section and section 407(e) of the Act.

(b) For purposes of paragraph (a)(2) of this section and section 407(d)(5) of the Act, the term ''marketable obligation'' means a bond, debenture, note, or certificate, or other evidence of indebtedness (hereinafter in this paragraph referred to as ''obligation'') if:

(1) Such obligation is acquired—

(i) On the market, either—

(A) At the price of the obligation prevailing on a national securities exchange which is registered with the Securities and Exchange Commission, or

(B) If the obligation is not traded on such a national securities exchange, at a price not less favorable to the plan

than the offering price for the obligation as established by current bid and asked prices quoted by persons independent of the issuer;

(ii) From an underwriter, at a price—

(A) Not in excess of the public offering price for the obligation as set forth in a prospectus or offering circular filed with the Securities and Exchange Commission, and

(B) At which a substantial portion of the same issue is acquired by persons independent of the issuer; or

(iii) Directly from the issuer at a price not less favorable to the plan than the price paid currently for a substantial portion of the same issue by persons independent of the issuer;

(2) Immediately following acquisition of such obligation,

(i) Not more than 25 percent of the aggregate amount of obligations issued in such issue and outstanding at the time of acquisition is held by the plan, and

(ii) At least 50 percent of the aggregate amount referred to in paragraph (A) is held by persons independent of the issuer; and

(3) Immediately following acquisition of the obligation, not more than 25 percent of the assets of the plan is invested in obligations of the employer or an affiliate of the employer.

[42 FR 44388, Sept. 2, 1977]

§ 2550.407d–6 Definition of the term "employee stock ownership plan".

(a) *In general*—(1) *Type of plan*. To be an ''ESOP'' (employee stock ownership plan), a plan described in section 407(d)(6)(A) of the Employee Retirement Income Security Act of 1974 (the Act) must meet the requirements of this section. See section 407(d)(6)(B).

(2) *Designation as ESOP*. To be an ESOP, a plan must be formally designated as such in the plan document.

(3) *Retroactive amendment*. A plan meets the requirements of this section as of the date that it is designated as an ESOP if it is amended retroactively to meet, and in fact does meet, such requirements at any of the following times:

(i) 12 months after the date on which the plan is designated as an ESOP;

(ii) 90 days after a determination letter is issued with respect to the qualification of the plan as an ESOP under this section, but only if the determination is requested by the date in paragraph (a)(3)(i) of this section; or

(iii) A later date approved by the Internal Revenue Service district director.

(4) *Addition to other plan*. An ESOP may form a portion of a plan the balance of which includes a qualified pension, profit-sharing, or stock bonus plan which is not an ESOP. A reference to an ESOP includes an ESOP that forms a portion of another plan.

(5) *Conversion of existing plan to an ESOP*. If an existing pension, profit-sharing, or stock bonus plan is converted into an ESOP, the requirements of section 404 of the Act, relating to fiduciary duties, and section 401(a) of the Internal Revenue Code (the Code), relating to requirements for plans established for the exclusive benefit of employees, apply to such conversion. A conversion may constitute a termination of an existing plan. For definition of a termination, see the regulations under section 411(d)(3) of the Code and section 4041(f) of the Act.

(6) *Certain arrangements barred*—(i) *Buy-sell agreements*. An arrangement involving an ESOP that creates a put option must not provide for the issuance of put options other than as provided under § 2550.408b–3 (j), (k) and (l). Also, an ESOP must not otherwise obligate itself to acquire securities from a particular security holder at an indefinite time determined upon the happening of an event such as the death of the holder.

(b) *Plan designed to invest primarily in qualifying employer securities*. A plan constitutes an ESOP only if the plan specifically states that it is designed to invest primarily in qualifying employer securities. Thus, a stock bonus plan or a money purchase pension plan constituting an ESOP may invest part of its assets in other than qualifying employer securities. Such plan will be treated the same as other stock bonus plans or money purchase pension plans qualified under section 401(a) of the Code with respect to those investments.

(c) *Regulations of the Secretary of the Treasury*. A plan constitutes an ESOP for a plan year only if it meets such

other requirements as the Secretary of the Treasury may prescribe by regulation under section 4975(e)(7) of the Code. (See 26 CFR 54.4975–11).

[42 FR 44388, Sept. 2, 1977]

§ 2550.408b–1 General statutory exemption for loans to plan participants and beneficiaries who are parties in interest with respect to the plan.

(a)(1) *In general.* Section 408(b)(1) of the Employee Retirement Income Security Act of 1974 (the Act or ERISA) exempts from the prohibitions of section 406(a), 406(b)(1) and 406(b)(2) loans by a plan to parties in interest who are participants or beneficiaries of the plan, provided that such loans:

(i) Are available to all such participants and beneficiaries on a reasonably equivalent basis;

(ii) Are not made available to highly compensated employees, officers or shareholders in an amount greater than the amount made available to other employees;

(iii) Are made in accordance with specific provisions regarding such loans set forth in the plan;

(iv) Bear a reasonable rate of interest; and

(v) Are adequately secured.

The Internal Revenue Code (the Code) contains parallel provisions to section 408(b)(1) of the Act. Effective, December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to promulgate regulations of the type published herein to the Secretary of Labor. Therefore, all references herein to section 408(b)(1) of the Act should be read to include reference to the parallel provisions of section 4975(d)(1) of the Code.

Section 1114(b)(15)(B) of the Tax Reform Act of 1986 amended section 408(b)(1)(B) of ERISA by deleting the phrase ''highly compensated employees, officers or shareholders'' and substituting the phrase ''highly compensated employees (within the meaning of section 414(q) of the Internal Revenue Code of 1986).'' Thus, for plans with participant loan programs which are subject to the amended section 408(b)(1)(B), the requirements of this regulation should be read to conform with the amendment.

(2) *Scope.* Section 408(b)(1) of the Act does not contain an exemption from acts described in section 406(b)(3) of the Act (prohibiting fiduciaries from receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving plan assets). If a loan from a plan to a participant who is a party in interest with respect to that plan involves an act described in section 406(b)(3), such an act constitutes a separate transaction which is not exempt under section 408(b)(1) of the Act. The provisions of section 408(b)(1) are further limited by section 408(d) of the Act (relating to transactions with owner-employees and related persons).

(3) *Loans.* (i) Section 408(b)(1) of the Act provides relief from the prohibitions of section 406(a), 406(b)(1) and 406(b)(2) for the making of a participant loan. The term ''participant loan'' refers to a loan which is arranged and approved by the fiduciary administering the loan program primarily in the interest of the participant and which otherwise satisfies the criteria set forth in section 408(b)(1) of the Act. The existence of a participant loan or participant loan program will be determined upon consideration of all relevant facts and circumstances. Thus, for example, the mere presence of a loan document appearing to satisfy the requirements of section 408(b)(1) will not be dispositive of whether a participant loan exists where the subsequent administration of the loan indicates that the parties to the loan agreement did not intend the loan to be repaid. Moreover, a loan program containing a precondition designed to benefit a party in interest (other than the participant) is not afforded relief by section 408(b)(1) or this regulation. In this regard, section 408(b)(1) recognizes that a program of participant loans, like other plan investments, must be prudently established and administered for the exclusive purpose of providing benefits to participants and beneficiaries of the plan.

(ii) For the purpose of this regulation, the term ''loan'' will include any renewal or modification of an existing loan agreement, provided that, at the

time of each such renewal or modification, the requirements of section 408(b)(1) and this regulation are met.

(4) *Examples*. The following examples illustrate the provisions of § 2550.408b–1(a).

Example (1): T, a trustee of plan P, has exclusive discretion over the management and disposition of plan assets. As a result, T is a fiduciary with respect to P under section 3(21)(A) of the Act and a party in interest with respect to P pursuant to section 3(14)(A) of the Act. T is also a participant in P. Among T's duties as fiduciary is the administration of a participant loan program which meets the requirements of section 408(b)(1) of the Act. Pursuant to strict objective criteria stated under the program, T, who participates in all loan decisions, receives a loan on the same terms as other participants. Although the exercise of T's discretion on behalf of himself may constitute an act of self-dealing described in section 406(b)(1), section 408(b)(1) provides an exemption from section 406(b)(1). As a result, the loan from P to T would be exempt under section 408(b)(1), provided the conditions of that section are otherwise satisfied.

Example (2): P is a plan covering all the employees of E, the employer who established and maintained P. F is a fiduciary with respect to P and an officer of E. The plan documents governing P give F the authority to establish a participant loan program in accordance with section 408(b)(1) of the Act. Pursuant to an arrangement with E, F establishes such a program but limits the use of loan funds to investments in a limited partnership which is established and maintained by E as general partner. Under these facts, the loan program and any loans made pursuant to this program are outside the scope of relief provided by section 408(b)(1) because the loan program is designed to operate for the benefit of E. Under the circumstances described, the diversion of plan assets for E's benefit would also violate sections 403(c)(1) and 404(a) of the Act.

Example (3): Assume the same facts as in Example 2, above, except that F does not limit the use of loan funds. However, E pressures his employees to borrow funds under P's participant loan program and then reloan the loan proceeds to E. F, unaware of E's activities, arranges and approves the loans. If the loans meet all the conditions of section 408(b)(1), such loans will be exempt under that section. However, E's activities would cause the entire transaction to be viewed as an indirect transfer of plan assets between P and E, who is a party in interest with respect to P, but not the participant borrowing from P. By coercing the employees to engage in loan transactions for its benefit, E has engaged in separate transactions that are not exempt under section 408(b)(1). Accordingly, E would be liable for the payment of excise taxes under section 4975 of the Code.

Example (4): Assume the same facts as in Example 2, above, except that, in return for structuring and administering the loan program as indicated, E agrees to pay F an amount equal to 10 percent of the funds loaned under the program. Such a payment would result in a separate transaction not covered by section 408(b)(1). This transaction would be prohibited under section 406(b)(3) since F would be receiving consideration from a party in connection with a transaction involving plan assets.

Example (5): F is a fiduciary with respect to plan P. D is a party in interest with respect to plan P. Section 406(a)(1)(B) of the Act would prohibit F from causing P to lend money to D. However, F enters into an agreement with Z, a plan participant, whereby F will cause P to make a participant loan to Z with the express understanding that Z will subsequently lend the loan proceeds to D. An examination of Z's credit standing indicates that he is not creditworthy and would not, under normal circumstances, receive a loan under the conditions established by the participant loan program. F's decision to approve the participant loan to Z on the basis of Z's prior agreement to lend the money to D violates the exclusive purpose requirements of sections 403(c) and 404(a). In effect, the entire transaction is viewed as an indirect transfer of plan assets between P and D, and not a loan to a participant exempt under section 408(b)(1). Z's lack of credit standing would also cause the transaction to fail under section 408(b)(1)(A) of the Act.

Example (6): F is a fiduciary with respect to Plan P. Z is a plan participant. Z and D are both parties in interest with respect to P. F approves a participant loan to Z in accordance with the conditions established under the participant loan program. Upon receipt of the loan, Z intends to lend the money to D. If F has approved this loan solely upon consideration of those factors which would be considered in a normal commercial setting by an entity in the business of making comparable loans, Z's subsequent use of the loan proceeds will not affect the determination of whether loans under P's program satisfy the conditions of section 408(b)(1).

Example (7): A is the trustee of a small individual account plan. D, the president of the plan sponsor, is also a participant in the plan. Pursuant to a participant loan program meeting the requirements of section 408(b)(1), D applies for a loan to be secured by a parcel of real property. D does not intend to repay the loan; rather, upon eventual default, he will permit the property to be foreclosed upon and transferred to the plan in discharge of his legal obligation to repay the loan. A, aware of D's intention, approves the

loan. D fails to make two consecutive quarterly payments of principal and interest under the note evidencing the loan thereby placing the loan in default. The plan then acquires the real property upon foreclosure. Such facts and circumstances indicate that the payment of money from the plan to D was not a participant loan eligible for the relief afforded by section 408(b)(1). In effect, this transaction is a prohibited sale or exchange of property between a plan and a party in interest from the time D receives the money.

Example (8): Plan P establishes a participant loan program. All loans are subject to the condition that the borrowed funds must be used to finance home purchases. Interest rates on the loans are the same as those charged by a local savings and loan association under similar circumstances. A loan by P to a participant to finance a home purchase would be subject to the relief provided by section 408(b)(1) provided that the conditions of 408(b)(1) are met. A participant loan program which is established to make loans for certain stated purposes (e.g., hardship, college tuition, home purchases, etc.) but which is not otherwise designed to benefit parties in interest (other than plan participants) would not, in itself, cause such program to be ineligible for the relief provided by section 408(b)(1). However, fiduciaries are cautioned that operation of a loan program with limitations may result in loans not being made available to all participants and beneficiaries on a reasonably equivalent basis.

(b) *Reasonably equivalent basis.* (1) Loans will not be considered to have been made available to participants and beneficiaries on a reasonably equivalent basis unless:

(i) Such loans are available to all plan participants and beneficiaries without regard to any individual's race, color, religion, sex, age or national origin;

(ii) In making such loans, consideration has been given only to those factors which would be considered in a normal commercial setting by an entity in the business of making similar types of loans. Such factors may include the applicant's creditworthiness and financial need; and

(iii) An evaluation of all relevant facts and circumstances indicates that, in actual practice, loans are not unreasonably withheld from any applicant.

(2) A participant loan program will not fail the requirement of paragraph (b)(1) of this section or § 2550.408b–1(c) if the program establishes a minimum loan amount of up to $1,000, provided that the loans granted meet the requirements of § 2550.408b–1(f).

(3) *Examples.* The following examples illustrate the provisions of § 2550.408b–1(b)(1):

Example (1): T, a trustee of plan P, has exclusive discretion over the management and disposition of plan assets. T's duties include the administration of a participant loan program which meets the requirements of section 408(b)(1) of the Act. T receives a participant loan at a lower interest rate than the rate made available to other plan participants of similar financial condition or creditworthiness with similar security. The loan by P to T would not be covered by the relief provided by section 408(b)(1) because loans under P's program are not available to all plan participants on a reasonably equivalent basis.

Example (2): Same facts as in example 1, except that T is a member of a committee of trustees responsible for approving participant loans. T pressures the committee to refuse loans to other qualified participants in order to assure that the assets allocated to the participant loan program would be available for a loan by P to T. The loan by P to T would not be covered by the relief provided by section 408(b)(1) since participant loans have not been made available to all participants and beneficiaries on a reasonably equivalent basis.

Example (3): T is the trustee of plan P, which covers the employees of E. A, B and C are employees of E, participants in P, and friends of T. The documents governing P provide that T, in his discretion, may establish a participant loan program meeting certain specified criteria. T institutes such a program and tells A, B and C of his decision. Before T is able to notify P's other participants and beneficiaries of the loan program, A, B, and C file loan applications which, if approved, will use up substantially all of the funds set aside for the loan program. Approval of these applications by T would represent facts and circumstances showing that loans under P's program are not available to all participants and beneficiaries on a reasonably equivalent basis.

(c) *Highly compensated employees.* (1) Loans will not be considered to be made available to highly compensated employees, officers or shareholders in an amount greater than the amount made available to other employees if, upon consideration of all relevant facts and circumstances, the program does not operate to exclude large numbers of plan participants from receiving loans under the program.

(2) A participant loan program will not fail to meet the requirement in paragraph (c)(1), of this section, merely because the plan documents specifically governing such loans set forth either (i) a maximum dollar limitation, or (ii) a maximum percentage of vested accrued benefit which no loan may exceed.

(3) If the second alternative in paragraph (c)(2) of this section (maximum percentage of vested accrued benefit) is chosen, a loan program will not fail to meet this requirement solely because maximum loan amounts will vary directly with the size of the participant's accrued benefit.

(4) *Examples*. The following examples illustrate the provisions of § 2550.408b–1(c).

Example (1): The documents governing plan P provide for the establishment of a participant loan program in which the amount of any loan under the program (when added to the outstanding balances of any other loans under the program to the same participant) does not exceed the lesser of (i) $50,000, or (ii) one-half of the present value of that participant's vested accrued benefit under the plan (but not less than $10,000). P's participant loan program does not fail to meet the requirement in section 408(b)(1)(B) of the Act, and would be covered by the relief provided by section 408(b)(1) if the other conditions of that section are met.

Example (2): The documents governing plan T provide for the establishment of a participant loan program in which the minimum loan amount would be $25,000. The documents also require that the only security acceptable under the program would be the participant's vested accrued benefit. A, the plan fiduciary administering the loan program, finds that because of the restrictions in the plan documents only 20 percent of the plan participants, all of whom earn in excess of $75,000 a year, would meet the threshold qualifications for a loan. Most of these participants are high-level supervisors or corporate officers. Based on these facts, it appears that loans under the program would be made available to highly compensated employees in an amount greater than the amount made available to other employees. As a result, the loan program would fail to meet the requirement in section 408(b)(1)(B) of the Act and would not be covered by the relief provided in section 408(b)(1).

(d) *Specific plan provisions*. For the purpose of section 408(b)(1) and this regulation, the Department will consider that participant loans granted or renewed at any time prior to the last day of the first plan year beginning on or after January 1, 1989, are made in accordance with specific provisions regarding such loans set forth in the plan if:

(1) The plan provisions regarding such loans contain (at a minimum) an explicit authorization for the plan fiduciary responsible for investing plan assets to establish a participant loan program; and

(2) For participant loans granted or renewed on or after the last day of the first plan year beginning on or after January 1, 1989, the participant loan program which is contained in the plan or in a written document forming part of the plan includes, but need not be limited to, the following:

(i) The identity of the person or positions authorized to administer the participant loan program;

(ii) A procedure for applying for loans;

(iii) The basis on which loans will be approved or denied;

(iv) Limitations (if any) on the types and amount of loans offered;

(v) The procedure under the program for determining a reasonable rate of interest;

(vi) The types of collateral which may secure a participant loan; and

(vii) The events constituting default and the steps that will be taken to preserve plan assets in the event of such default.

Example (1): Plan P authorizes the trustee to establish a participant loan program in accordance with section 408(b)(1) of the Act. Pursuant to this explicit authority, the trustee establishes a written program which contains all of the information required by § 2550.408b–1(d)(2). Loans made pursuant to this authorization and the written loan program will not fail under section 408(b)(1)(C) of the Act merely because the specific provisions regarding such loans are contained in a separate document forming part of the plan. The specific provisions describing the loan program, whether contained in the plan or in a written document forming part of a plan, do affect the rights and obligations of the participants and beneficiaries under the plan and, therefore, must in accordance with section 102(a)(1) of the Act, be disclosed in the plan's summary plan description.

(e) *Reasonable rate of interest*. A loan will be considered to bear a reasonable rate of interest if such loan provides

the plan with a return commensurate with the interest rates charged by persons in the business of lending money for loans which would be made under similar circumstances.

Example (1): Plan P makes a participant loan to A at the fixed interest rate of 8% for 5 years. The trustees, prior to making the loan, contacted two local banks to determine under what terms the banks would make a similar loan taking into account A's creditworthiness and the collateral offered. One bank would charge a variable rate of 10% adjusted monthly for a similar loan. The other bank would charge a fixed rate of 12% under similar circumstances. Under these facts, the loan to A would not bear a reasonable rate of interest because the loan did not provide P with a return commensurate with interest rates charged by persons in the business of lending money for loans which would be made under similar circumstances. As a result, the loan would fail to meet the requirements of section 408(b)(1)(D) and would not be covered by the relief provided by section 408(b)(1) of the Act.

Example (2): Pursuant to the provisions of plan P's participant loan program, T, the trustee of P, approves a loan to M, a participant and party in interest with respect to P. At the time of execution, the loan meets all of the requirements of section 408(b)(1) of the Act. The loan agreement provides that at the end of two years M must pay the remaining balance in full or the parties may renew for an additional two year period. At the end of the initial two year period, the parties agree to renew the loan for an additional two years. At the time of renewal, however, A fails to adjust the interest rate charged on the loan in order to reflect current economic conditions. As a result, the interest rate on the renewal fails to provide a ''reasonable rate of interest'' as required by section 408(b)(1)(D) of the Act. Under such circumstances, the loan would not be exempt under section 408(b)(1) of the Act from the time of renewal.

Example (3): The documents governing plan P's participant loan program provide that loans must bear an interest rate no higher than the maximum interest rate permitted under State X's usury law. Pursuant to the loan program, P makes a participant loan to A, a plan participant, at a time when the interest rates charged by financial institutions in the community (not subject to the usury limit) for similar loans are higher than the usury limit. Under these circumstances, the loan would not bear a reasonable rate of interest because the loan does not provide P with a return commensurate with the interest rates charged by persons in the business of lending money under similar circumstances. In addition, participant loans that are artificially limited to the maximum usury ceiling then prevailing call into question the status of such loans under sections 403(c) and 404(a) where higher yielding comparable investment opportunities are available to the plan.

(f) *Adequate security*. (1) A loan will be considered to be adequately secured if the security posted for such loan is something in addition to and supporting a promise to pay, which is so pledged to the plan that it may be sold, foreclosed upon, or otherwise disposed of upon default of repayment of the loan, the value and liquidity of which security is such that it may reasonably be anticipated that loss of principal or interest will not result from the loan. The adequacy of such security will be determined in light of the type and amount of security which would be required in the case of an otherwise identical transaction in a normal commercial setting between unrelated parties on arm's-length terms. A participant's vested accrued benefit under a plan may be used as security for a participant loan to the extent of the plan's ability to satisfy the participant's outstanding obligation in the event of default.

(2) For purposes of this paragraph,

(i) No more than 50% of the present value of a participant's vested accrued benefit may be considered by a plan as security for the outstanding balance of all plan loans made to that participant;

(ii) A plan will be in compliance with paragraph (f)(2)(i) of this section if, with respect to any participant, it meets the provisions of paragraph (f)(2)(i) of this section immediately after the origination of each participant loan secured in whole or in part by that participant's vested accrued benefit; and

(iii) Any loan secured in whole or in part by a portion of a participant's vested accrued benefit must also meet the requirements of paragraph (f)(1) of this section.

(g) *Effective date*. This section is effective for all participant loans granted or renewed after October 18, 1989, except with respect to paragraph (d)(2) of this section relating to specific plan provisions. Paragraph (d)(2) of this section is effective for participant loans granted or renewed on or after the last

day of the first plan year beginning on or after January 1, 1989.

(Approved by the Office of Management and Budget under control number 1210–0076)

[54 FR 30528, July 20, 1989]

§ 2550.408b–2 General statutory exemption for services or office space.

(a) *In general.* Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406(a) of the Act payment by a plan to a party in interest, including a fiduciary, for office space or any service (or a combination of services) if:

(1) Such office space or service is necessary for the establishment or operation of the plan;

(2) Such office space or service is furnished under a contract or arrangement which is reasonable; and

(3) No more than reasonable compensation is paid for such office space or service.

However, section 408(b)(2) does not contain an exemption from acts described in section 406(b)(1) of the Act (relating to fiduciaries dealing with the assets of plans in their own interest or for their own account), section 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries) or section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the assets of the plan). Such acts are separate transactions not described in section 408(b)(2). See § 2250.408b–2 (e) and (f) for guidance as to whether transactions relating to the furnishing of office space or services by fiduciaries to plans involve acts described in section 406(b)(1) of the Act. Section 408(b)(2) of the Act does not contain an exemption from other provisions of the Act, such as section 404, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 408(b)(2). See, for example, section 401 of the Internal Revenue Code of 1954. The provisions of section 408(b)(2) of the Act are further limited by section 408(d) of the Act (relating to transactions with owner-employees and related persons).

(b) *Necessary service.* A service is necessary for the establishment or operation of a plan within the meaning of section 408(b)(2) of the Act and § 2550.408b–2(a)(1) if the service is appropriate and helpful to the plan obtaining the service in carrying out the purposes for which the plan is established or maintained. A person providing such a service to a plan (or a person who is a party in interest solely by reason of a relationship to such a service provider described in section 3(14)(F), (G), (H), or (I) of the Act) may furnish goods which are necessary for the establishment or operation of the plan in the course of, and incidental to, the furnishing of such service to the plan.

(c) *Reasonable contract or arrangement.* No contract or arrangement is reasonable within the meaning of section 408(b)(2) of the Act and § 2550.408b–2(a)(2) if it does not permit termination by the plan without penalty to the plan on reasonably short notice under the circumstances to prevent the plan from becoming locked into an arrangement that has become disadvantageous. A long-term lease which may be terminated prior to its expiration (without penalty to the plan) on reasonably short notice under the circumstances is not generally an unreasonable arrangement merely because of its long term. A provision in a contract or other arrangement which reasonably compensates the service provider or lessor for loss upon early termination of the contract, arrangement or lease is not a penalty. For example, a minimal fee in a service contract which is charged to allow recoupment of reasonable start-up costs is not a penalty. Similary, a provision in a lease for a termination fee that covers reasonably foreseeable expenses related to the vacancy and re-letting of the office space upon early termination of the lease is not a penalty. Such a provision does not reasonably compensate for loss if it provides for payment in excess of actual loss or if it fails to require mitigation of damages.

(d) *Reasonable compensation*. Section 408(b)(2) of the Act and § 2550.408b–2(a)(3) permit a plan to pay a party in interest reasonable compensation for the provision of office space or services described in section 408(b)(2). Section 2550.408c–2 of these regulations contains provisions relating to what constitutes reasonable compensation for the provision of services.

(e) *Transactions with fiduciaries*—(1) *In general*. If the furnishing of office space or a service involves an act described in section 406(b) of the Act (relating to acts involving conflicts of interest by fiduciaries), such an act constitutes a separate transaction which is not exempt under section 408(b)(2) of the Act. The prohibitions of section 406(b) supplement the other prohibitions of section 406(a) of the Act by imposing on parties in interest who are fiduciaries a duty of undivided loyalty to the plans for which they act. These prohibitions are imposed upon fiduciaries to deter them from exercising the authority, control, or responsibility which makes such persons fiduciaries when they have interests which may conflict with the interests of the plans for which they act. In such cases, the fiduciaries have interests in the transactions which may affect the exercise of their best judgment as fiduciaries. Thus, a fiduciary may not use the authority, control, or responsibility which makes such person a fiduciary to cause a plan to pay an additional fee to such fiduciary (or to a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary) to provide a service. Nor may a fiduciary use such authority, control, or responsibility to cause a plan to enter into a transaction involving plan assets whereby such fiduciary (or a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary) will receive consideration from a third party in connection with such transaction. A person in which a fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary includes, for example, a person who is a party in interest by reason of a relationship to such fiduciary described in section 3(14)(E), (F), (G), (H), or (I).

(2) *Transactions not described in section 406(b)(1)*. A fiduciary does not engage in an act described in section 406(b)(1) of the Act if the fiduciary does not use any of the authority, control or responsibility which makes such person a fiduciary to cause a plan to pay additional fees for a service furnished by such fiduciary or to pay a fee for a service furnished by a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary. This may occur, for example, when one fiduciary is retained on behalf of a plan by a second fiduciary to provide a service for an additional fee. However, because the authority, control or responsibility which makes a person a fiduciary may be exercised ''in effect'' as well as in form, mere approval of the transaction by a second fiduciary does not mean that the first fiduciary has not used any of the authority, control or responsibility which makes such person a fiduciary to cause the plan to pay the first fiduciary an additional fee for a service. See paragraph (f) of this section.

(3) *Services without compensation*. If a fiduciary provides services to a plan without the receipt of compensation or other consideration (other than reimbursement of direct expenses properly and actually incurred in the performance of such services within the meaning of § 2550.408c–2(b)(3)), the provision of such services does not, in and of itself, constitute an act described in section 406(b) of the Act. The allowance of a deduction to an employer under section 162 or 212 of the Code for the expense incurred in furnishing office space or services to a plan established or maintained by such employer does not constitute compensation or other consideration.

(f) *Examples*. The provisions of § 2550.408b–2(e) may be illustrated by the following examples.

Example (1). E, an employer whose employees are covered by plan P, is a fiduciary of P. I is a professional investment adviser in which E has no interest which may affect the exercise of E's best judgment as a fiduciary. E causes P to retain I to provide certain kinds of investment advisory services of a type which causes I to be a fiduciary of P

under section 3(21)(A)(ii) of the Act. thereafter, I proposes to perform for additional fees portfolio evaluation services in addition to the services currently provided. The provision of such services is arranged by I and approved on behalf of the plan by E. I has not engaged in an act described in section 406(b)(1) of the Act, because I did not use any of the authority, control or responsibility which makes I a fiduciary (the provision of investment advisory services) to cause the plan to pay I additional fees for the provision of the portfolio evaluation services. E has not engaged in an act which is described in section 406(b)(1). E, as the fiduciary who has the responsibility to be prudent in his selection and retention of I and the other investment advisers of the plan, has an interest in the purchase by the plan of portfolio evaluation services. However, such an interest is not an interest which may affect the exercise of E's best judgment as a fiduciary.

Example (2). D, a trustee of plan P with discretion over the management and disposition of plan assets, relies on the advice of C, a consultant to P, as to the investment of plan assets, thereby making C a fiduciary of the plan. On January 1, 1978, C recommends to D that the plan purchase an insurance policy from U, an insurance company which is not a party in interest with respect to P. C thoroughly explains the reasons for the recommendation and makes a full disclosure concerning the fact that C will receive a commission from U upon the purchase of the policy of P. D considers the recommendation and approves the purchase of the policy by P. C receives a commission. Under such circumstances, C has engaged in an act described in section 406(b)(1) of the Act (as well as sections 406(b)(2) and (3) of the Act) because C is in fact exercising the authority, control or responsibility which makes C a fiduciary to cause the plan to purchase the policy. However, the transaction is exempt from the prohibited transaction provisions of section 406 of the Act, if the requirements of Prohibited Transaction Exemption 77–9 are met.

Example (3). Assume the same facts as in Example (2) except that the nature of C's relationship with the plan is not such that C is a fiduciary of P. The purchase of the insurance policy does not involve an act described in section 406(b)(1) of the Act (or sections 406(b)(2) or (3) of the Act) because such sections only apply to acts by fiduciaries.

Example (4). E, an employer whose employees are covered by plan P, is a fiduciary with respect to P. A, who is not a party in interest with respect to P, persuades E that the plan needs the services of a professional investment adviser and that A should be hired to provide the investment advice. Accordingly, E causes P to hire A to provide investment advice of the type which makes A a fiduciary under § 2510.3–21(c)(1)(ii)(B). Prior to the expiration of A's first contract with P, A persuades E to cause P to renew A's contract with P to provide the same services for additional fees in view of the increased costs in providing such services. During the period of A's second contract, A provides additional investment advice services for which no additional charge is made. Prior to the expiration of A's second contract, A persuades E to cause P to renew his contract for additional fees in view of the additional services A is providing. A has not engaged in an act described in section 406(b)(1) of the Act, because A has not used any of the authority, control or responsibility which makes A a fiduciary (the provision of investment advice) to cause the plan to pay additional fees for A's services.

Example (5). F, a trustee of plan P with discretion over the management and disposition of plan assets, retains C to provide administrative services to P of the type which makes C a fiduciary under section 3(21)(A)(iii). Thereafter, C retains F to provide for additional fees actuarial and various kinds of administrative services in addition to the services F is currently providing to P. Both F and C have engaged in an act described in section 406(b)(1) of the Act. F, regardless of any intent which he may have had at the time he retained C, has engaged in such an act because F has, in effect, exercised the authority, control or responsibility which makes F a fiduciary to cause the plan to pay F additional fees for the services. C, whose continued employment by P depends on F, has also engaged in such an act, because C has an interest in the transaction which might affect the exercise of C's best judgment as a fiduciary. As a result, C has dealt with plan assets in his own interest under section 406(b)(1).

Example (6). F, a fiduciary of plan P with discretionary authority respecting the management of P, retains S, the son of F, to provide for a fee various kinds of administrative services necessary for the operation of the plan. F has engaged in an act described in section 406(b)(1) of the Act because S is a person in whom F has an interest which may affect the exercise of F's best judgment as a fiduciary. Such act is not exempt under section 408(b)(2) of the Act irrespective of whether the provision of the services by S is exempt.

Example (7). T, one of the trustees of plan P, is president of bank B. The bank proposes to provide administrative services to P for a fee. T physically absents himself from all consideration of B's proposal and does not otherwise exercise any of the authority, control or responsibility which makes T a fiduciary to cause the plan to retain B. The other trustees decide to retain B. T has not engaged in an act described in section 406(b)(1) of the Act. Further, the other trustees have not engaged in an act described in

section 406(b)(1) merely because T is on the board of trustees of P. This fact alone would not make them have an interest in the transaction which might affect the exercise of their best judgment as fiduciaries.

[42 FR 32390, June 24, 1977]

§ 2550.408b–3 Loans to Employee Stock Ownership Plans.

(a) *Definitions*. When used in this section, the terms listed below have the following meanings:

(1) *ESOP*. The term *ESOP* refers to an employee stock ownership plan that meets the requirements of section 407(d)(6) of the Employee Retirement Income Security Act of 1974 (the Act) and 29 CFR 2550.407d–6. It is not synonymous with ''stock bonus plan.'' A stock bonus plan must, however, be an ESOP to engage in an exempt loan. The qualification of an ESOP under section 401 (a) of the Internal Revenue Code (the Code) and 26 CFR 54.4975–11 will not be adversely affected merely because it engages in a non-exempt loan.

(2) *Loan*. The term *loan* refers to a loan made to an ESOP by a party in interest or a loan to an ESOP which is guaranteed by a party in interest. It includes a direct loan of cash, a purchase-money transaction, and an assumption of the obligation of an ESOP. ''Guarantee'' includes an unsecured guarantee and the use of assets of a party in interest as collateral for a loan, even though the use of assets may not be a guarantee under applicable state law. An amendment of a loan in order to qualify as an exempt loan is not a refinancing of the loan or the making of another loan.

(3) *Exempt loan*. The term *exempt loan* refers to a loan that satisfies the provisions of this section. A ''non-exempt loan'' is one that fails to satisfy such provisions.

(4) *Publicly traded*. The term *publicly traded* refers to a security that is listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 (15 U.S.C. 78f) or that is quoted on a system sponsored by a national securities association registered under section 15A(b) of the Securities Exchange Act (15 U.S.C. 78o).

(5) *Qualifying employer security*. The term *qualifying employer security* reters to a security described in 29 CFR 2550.407d–5.

(b) *Statutory exemption*—(1) *Scope*. Section 408(b)(3) of the Act provides an exemption from the prohibited transaction provisions of sections 406(a) and 406(b)(1) of the Act (relating to fiduciaries dealing with the assets of plans in their own interest or for their own account) and 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries). Section 408(b)(3) does not provide an exemption from the prohibitions of section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan).

(2) *Special scrutiny of transaction*. The exemption under section 408(b)(3) includes within its scope certain transaction in which the potential for self-dealing by fiduciaries exists and in which the interests of fiduciaries may conflict with the interests of participants. To guard against these potential abuses, the Department of Labor will subject these transactions to special scrutiny to ensure that they are primarily for the benefit of participants and their beneficiaries. Although the transactions need not be arranged and approved by an independent fiduciary, fiduciaries are cautioned to scrupulously exercise their discretion in approving them. For example, fiduciaries should be prepared to demonstrate compliance with the net effect test and the arm's-length standard under paragraphs (c)(2) and (3) of this section. Also, fiduciaries should determine that the transaction is truly arranged primarily in the interest of participants and their beneficiaries rather than, for example, in the interest of certain selling shareholders.

(c) *Primary benefit requirements*—(1) *In general*. An exempt loan must be primarily for the benefit of the ESOP participants and their beneficiaries. All the surrounding facts and circumstances, including those described

in paragraphs (c)(2) and (3) of this section, will be considered in determining whether such loan satisfies this requirement. However, no loan will satisfy such requirement unless it satisfies the requirements of paragraphs (d), (e) and (f) of this section.

(2) *Net effect on plan assets.* At the time that a loan is made, the interest rate for the loan and the price of securities to be acquired with the loan proceeds should not be such that plan assets might be drained off.

(3) *Arm's-length standard.* The terms of a loan, whether or not between independent parties, must, at the time the loan is made, be at least as favorable to the ESOP as the terms of a comparable loan resulting from arm's-length negotiations between independent parties.

(d) *Use of loan proceeds.* The proceeds of an exempt loan must be used, within a reasonable time after their receipt, by the borrowing ESOP only for any or all of the following purposes:

(1) To acquire qualifying employer securities.

(2) To repay such loan.

(3) To repay a prior exempt loan. A new loan, the proceeds of which are so used, must satisfy the provisions of this section.

Except as provided in paragraphs (i) and (j) of this section or as otherwise required by applicable law, no security acquired with the proceeds of an exempt loan may be subject to a put, call, or other option, or buy-sell or similar arrangement while held by and when distributed from a plan, whether or not the plan is then ESOP.

(e) *Liability and collateral of ESOP for loan.* An exempt loan must be without recourse against the ESOP. Furthermore, the only assets of the ESOP that may be given as collateral on an exempt loan are qualifying employer securities of two classes: Those acquired with the proceeds of the exempt loan and those that were used as collateral on a prior exempt loan repaid with the proceeds of the current exempt loan. No person entitled to payment under the exempt loan shall have any right to assets of the ESOP other than:

(1) Collateral given for the loan,

(2) Contributions (other than contributions of employer securities) that are made under an ESOP to meet its obligations under the loan, and

(3) Earnings attributable to such collateral and the investment of such contributions.

The payments made with respect to an exempt loan by the ESOP during a plan year must not exceed an amount equal to the sum of such contributions and earnings received during or prior to the year less such payments in prior years. Such contributions and earnings must be accounted for separately in the books of account of the ESOP until the loan is repaid.

(f) *Default.* In the event of default upon an exempt loan, the value of plan assets transferred in satisfaction of the loan must not exceed the amount of default. If the lender is a party in interest, a loan must provide for a transfer of plan assets upon default only upon and to the extent of the failure of the plan to meet the payment schedule of the loan. For purposes of this paragraph, the making of a guarantee does not make a person a lender.

(g) *Reasonable rate of interest.* The interest rate of a loan must not be in excess of a reasonable rate of interest. All relevant factors will be considered in determining a reasonable rate of interest, including the amount and duration of the loan, the security and guarantee (if any) involved, the credit standing of the ESOP and the guarantor (if any), and the interest rate prevailing for comparable loans. When these factors are considered, a variable interest rate may be reasonable.

(h) *Release from encumbrance*—(1) *General rule.* In general, an exempt loan must provide for the release from encumbrance of plan assets used as collateral for the loan under this paragraph. For each plan year during the duration of the loan, the number of securities released must equal the number of encumbered securities held immediately before release for the current plan year multiplied by a fraction. The numerator of the fraction is the amount of principal and interest paid for the year. The denominator of the fraction is the sum of the numerator plus the principal and interest to be paid for all future years. See § 2550.408b–3(h)(4). The number of future years under the loan must be definitely

ascertainable and must be determined without taking into account any possible extensions or renewal periods. If the interest rate under the loan is variable, the interest to be paid in future years must be computed by using the interest rate applicable as of the end of the plan year. If collateral includes more than one class of securities, the number of securities of each class to be released for a plan year must be determined by applying the same fraction to each class.

(2) *Special rule*. A loan will not fail to be exempt merely because the number of securities to be released from encumbrance is determined solely with reference to principal payments. However, if release is determined with reference to principal payments only, the following three additional rules apply. The first rule is that the loan must provide for annual payments of principal and interest at a cumulative rate that is not less rapid at any time than level annual payments of such amounts for 10 years. The second rule is that interest included in any payment is disregarded only to the extent that it would be determined to be interest under standard loan amortization tables. The third rule is that subdivision (2) is not applicable from the time that, by reason of a renewal, extension, or refinancing, the sum of the expired duration of the exempt loan, the renewal period, the extension period, and the duration of a new exempt loan exceeds 10 years.

(3) *Caution against plan disqualification*. Under an exempt loan, the number of securities released from encumbrance may vary from year to year. The release of securities depends upon certain employer contributions and earnings under the ESOP. Under 26 CFR 54.4975–11(d)(2) actual allocations to participants' accounts are based upon assets withdrawn from the suspense account. Nevertheless, for purposes of applying the limitations under section 415 of the Code to these allocations, under 26 CFR 54.4975–11(a)(8)(ii) contributions used by the ESOP to pay the loan are treated as annual additions to participants' accounts. Therefore, particular caution must be exercised to avoid exceeding the maximum annual additions under section 415 of the Code. At the same time, release from encumbrance in annually varying numbers may reflect a failure on the part of the employer to make substantial and recurring contributions to the ESOP which will lead to loss of qualification under section 401(a) of the Code. The Internal Revenue Service will observe closely the operation of ESOPs that release encumbered securities in varying annual amounts, particularly those that provide for the deferral of loan payments or for balloon payments. See 26 CFR 54.4975–7(b)(8)(iii).

(4) *Illustration*. The general rule under paragraph (h)(1) of this section operates as illustrated in the following examples:

Example. Corporation X establishes an ESOP that borrows $750,000 from a bank. X guarantees the loan which is for 15 years at 5% interest and is payable in level annual amounts of $72,256.72. Total payments on the loan are $1,083,850.80. The ESOP uses the entire proceeds of the loan to acquire 15,000 shares of X stock which is used as collateral for the loan. The number of securities to be released for the first year is 1,000 shares, i.e., 15,000 shares × $72,256.72/$1,083,850.80 = 15,000 shares × 1/15. The number of securities to be released for the second year is 1,000 shares, i.e., 14,000 shares × $72,256.72/$1,011,594.08 = 14,000 shares × 1/14. If all loan payments are made as originally scheduled, the number of securities released in each succeeding year of the loan will also be 1,000.

(i) *Right of first refusal*. Qualifying employer securities acquired with proceeds of an exempt loan may, but need not, be subject to a right of first refusal. However, any such right must meet the requirements of this paragraph. Securities subject to such right must be stock or an equity security, or a debt security convertible into stock or an equity security. Also, they must not be publicly traded at the time the right may be exercised. The right of first refusal must be in favor of the employer, the ESOP, or both in any order of priority. The selling price and other terms under the right must not be less favorable to the seller than the greater of the value of the security determined under 26 CFR 54.4975–11(d)(5), or the purchase price and other terms offered by a buyer, other than the employer or the ESOP, making a good faith offer to purchase the security. The right of

first refusal must lapse no later than 14 days after the security holder gives written notice to the holder of the right that an offer by a third party to purchase the security has been received.

(j) *Put option.* A qualifying employer security acquired with the proceeds of an exempt loan by an ESOP after September 30, 1976, must be subject to a put option if it is not publicly traded when distributed or if it is subject to a trading limitation when distributed. For purposes of this paragraph, a ''trading limitation'' or a security is a restriction under any Federal or State securities law or any regulation thereunder, or an agreement (not prohibited by this section) affecting the security which would make the security not as freely tradeable as one not subject to such restriction. The put option must be exercisable only by a participant, by the participant's donees, or by a person (including an estate or its distributee) to whom the security passes by reason of a participant's death. (Under this paragraph ''participant'' means a participant and the beneficiaries of the participant under the ESOP.) The put option must permit a participant to put the security to the employer. Under no circumstances may the put option bind the ESOP. However, it may grant the ESOP an option to assume the rights and obligations of the employer at the time that the put option is exercised. If it is known at the time a loan is made that Federal or state law will be violated by the employer's honoring such put option, the put option must permit the security to be put, in a manner consistent with such law, to a third party (e.g., an affiliate of the employer or a shareholder other than the ESOP) that has substantial net worth at the time the loan is made and whose net worth is reasonably expected to remain substantial.

(k) *Duration of put option*—(1) *General rule.* A put option must be exercisable at least during a 15-month period which begins the date the security subject to the put option is distributed by the ESOP.

(2) *Special rule.* In the case of a security that is publicly traded without restriction when distributed but ceases to be so traded within 15 months after distribution, the employer must notify each security holder in writing on or before the tenth day after the date the security ceases to be so traded that for the remainder of the 15-month period the security is subject to a put option. The number of days between the tenth day and the date on which notice is actually given, if later than the tenth day, must be added to the duration of the put option. The notice must inform distributees of the terms of the put options that they are to hold. The terms must satisfy the requirements of paragraphs (j) through (l) of this section.

(l) *Other put option provisions*—(1) *Manner of exercise.* A put option is exercised by the holder notifying the employer in writing that the put option is being exercised.

(2) *Time excluded from duration of put option.* The period during which a put option is exercisable does not include any time when a distributee is unable to exercise it because the party bound by the put option is prohibited from honoring it by applicable Federal or State law.

(3) *Price.* The price at which a put option must be exercisable is the value of the security, determined in accordance with paragraph (d)(5) of 26 CFR 54.4975–11.

(4) *Payment terms.* The provisions for payment under a put option must be reasonable. The deferral of payment is reasonable if adequate security and a reasonable interest rate are provided for any credit extended and if the cumulative payments at any time are no less than the aggregate of reasonable periodic payments as of such time. Periodic payments are reasonable if annual installments, beginning with 30 days after the date the put option is exercised, are substantially equal. Generally, the payment period may not end more than 5 years after the date the put option is exercised. However, it may be extended to a date no later than the earlier of 10 years from the date the put option is exercised or the date the proceeds of the loan used by the ESOP to acquire the security subject to such put option are entirely repaid.

(5) *Payment restrictions.* Payment under a put option may be restricted by the terms of a loan, including one

used to acquire a security subject to a put option, made before November 1, 1977. Otherwise, payment under a put option must not be restricted by the provisions of a loan or any other arrangement, including the terms of the employer's articles of incorporation, unless so required by applicable state law.

(m) *Other terms of loan.* An exempt loan must be for a specific term. Such loan may not be payable at the demand of any person, except in the case of default.

(n) *Status of plan as ESOP.* To be exempt, a loan must be made to a plan that is an ESOP at the time of such loan. However, a loan to a plan formally designated as an ESOP at the time of the loan that fails to be an ESOP because it does not comply with section 401(a) of the Code or 26 CFR 54.4975–11 will be exempt as of the time of such loan if the plan is amended retroactively under section 401(b) of the Code or 26 CFR 54.4975–11(a)(4).

(o) *Special rules for certain loans*—(1) *Loans made before January 1, 1976.* A loan made before January 1, 1976, or made afterwards under a binding agreement in effect on January 1, 1976 (or under renewals permitted by the terms of such an agreement on that date) is exempt for the entire period of such loan if it otherwise satisfies the provisions of this section for such period, even though it does not satisfy the following provisions of this section:

(i) The last sentence of paragraph (d);

(ii) Paragraphs (e), (f), and (h)(1) and (2); and

(iii) Paragraphs (i) through (m), inclusive.

(2) *Loans made after December 31, 1975, but before November 1, 1977.* A loan made after December 31, 1975, but before November 1, 1977, or made afterwards under a binding agreement in effect on November 1, 1977 (or under renewals permitted by the terms of such an agreement on that date) is exempt for the entire period of such loan if it otherwise satisfies the provisions of this section for such period even though it does not satisfy the following provisions of this section:

(i) Paragraph (f);

(ii) The three provisions of paragraph (h)(2); and

(iii) Paragraph (i).

(3) *Release rule.* Notwithstanding paragraphs (o)(1) and (2) of this section, if the proceeds of a loan are used to acquire securities after November 1, 1977, the loan must comply by such date with the provisions of paragraph (h) of this section.

(4) *Default rule.* Notwithstanding paragraphs (o)(1) and (2) of this section, a loan by a party in interest other than a guarantor must satisfy the requirements of paragraph (f) of this section. A loan will satisfy these requirements if it is retroactively amended before November 1, 1977, to satisfy these requirements.

(5) *Put option rule.* With respect to a security distributed before November 1, 1977, the put option provisions of paragraphs (j), (k), and (l) of this section will be deemed satisfied as of the date the security is distributed if by December 31, 1977, the security is subject to a put option satisfying such provisions. For purposes of satisfying such provisions, the security will be deemed distributed on the date the put option is issued. However, the put option provisions need not be satisfied with respect to a security that is not owned on November 1, 1977, by a person in whose hands a put option must be exercisable.

(Approved by the Office of Management and Budget under control number 1210–0046)

[42 FR 44385, Sept. 2, 1977; 42 FR 45907, Sept. 13, 1977, as amended at 49 FR 18295, Apr. 30, 1984]

§ 2550.408b–4 Statutory exemption for investments in deposits of banks or similar financial institutions.

(a) *In general.* Section 408(b)(4) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406 of the Act the investment of all or a part of a plan's assets in deposits bearing a reasonable rate of interest in a bank or similar financial institution supervised by the United States or a State, even though such bank or similar financial insitution is a fiduciary or other party in interest with respect to the plan, if the conditions of either § 2550.408b–4(b)(1) or § 2550.408b–4(b)(2) are met. Section 408(b)(4) provides an exemption

from sections 406(b)(1) of the Act (relating to fiduciaries dealing with the assets of plans in their own interest or for their own account) and 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries), as well as section 406(a)(1), because section 408(b)(4) contemplates a bank or similar financial institution causing a plan for which it acts as a fiduciary to invest plan assets in its own deposits if the requirements of section 408(b)(4) are met. However, it does not provide an exemption from section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the assets of the plan). The receipt of such consideration is a separate transaction not described in the statutory exemption. Section 408(b)(4) does not contain an exemption from other provisions of the Act, such as section 404, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 408(b)(4) of the Act. See, for example, section 401 of the Internal Revenue Code of 1954 (Code). The provisions of section 408(b)(4) of the Act are further limited by section 408(d) of the Act (relating to transactions with owner-employees and related persons).

(b)(1) *Plan covering own employees.* Such investment may be made if the plan is one which covers only the employees of the bank or similar financial institution, the employees of any of its affiliates, or the employees of both.

(2) *Other plans.* Such investment may be made if the investment is expressly authorized by a provision of the plan or trust instrument or if the investment is expressly authorized (or made) by a fiduciary of the plan (other than the bank or similar financial institution or any of its affiliates) who has authority to make such investments, or to instruct the trustee or other fiduciary with respect to investments, and who has no interest in the transaction which may affect the exercise of such authorizing fiduciary's best judgment as a fiduciary so as to cause such authorization to consititute an act described in section 406(b) of the Act. Any authorization to make investments contained in a plan or trust instrument will satisfy the requirement of express authorization for investments made prior to November 1, 1977. Effective November 1, 1977, in the case of a bank or similar financial institution that invests plan assets in deposits in itself or its affiliates under an authorization contained in a plan or trust instrument, such authorization must name such bank or similar financial institution and must state that such bank or similar financial institution may make investments in deposits which bear a reasonable rate of interest in itself (or in an affiliate).

(3) *Example.* B, a bank, is the trustee of plan P's assets. The trust instruments give the trustees the right to invest plan assets in its discretion. B invests in the certificates of deposit of bank C, which is a fiduciary of the plan by virtue of performing certain custodial and administrative services. The authorization is sufficient for the plan to make such investment under section 408(b)(4). Further, such authorization would suffice to allow B to make investments in deposits in itself prior to November 1, 1977. However, subsequent to October 31, 1977, B may not invest in deposits in itself, unless the plan or trust instrument specifically authorizes it to invest in deposits of B.

(c) *Definitions.* (1) The term *bank or similar financial institution* includes a bank (as defined in section 581 of the Code), a domestic building and loan association (as defined in section 7701(a)(19) of the Code), and a credit union (as defined in section 101(6) of the Federal Credit Union Act).

(2) A person is an affiliate of a bank or similar financial institution if such person and such bank or similar financial institution would be treated as members of the same controlled group of corporations or as members of two or more trades or businesses under common control within the meaning of section 414 (b) or (c) of the Code and the regulations thereunder.

(3) The term *deposits* includes any account, temporary or otherwise, upon

which a reasonable rate of interest is paid, including a certificate of deposit issued by a bank or similar financial institution.

[42 FR 32392, June 24, 1977; 42 FR 36823, July 18, 1977]

§ 2550.408b–6 Statutory exemption for ancillary services by a bank or similar financial institution.

(a) *In general.* Section 408(b)(6) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406 of the Act the provision of certain ancillary services by a bank or similar financial institution (as defined in § 2550.408b–4(c)(1) supervised by the United States or a State to a plan for which it acts as a fiduciary if the conditions of § 2550.408b–6(b) are met. Such ancillary services include services which do not meet the requirements of section 408(b)(2) of the Act because the provision of such services involves an act described in section 406(b)(1) of the Act (relating to fiduciaries dealing with the assets of plans in their own interest or for their own account) by the fiduciary bank or similar financial institution or an act described in section 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries). Section 408(b)(6) provides an exemption from sections 406(b)(1) and (2) because section 408(b)(6) contemplates the provision of such ancillary services without the approval of a second fiduciary (as described in § 2550.408b–2(e)(2)) if the conditions of § 2550.408b–6(b) are met. Thus, for example, plan assets held by a fiduciary bank which are reasonably expected to be needed to satisfy current plan expenses may be placed by the bank in a non-interest-bearing checking account in the bank if the conditions of § 2550.408b–6(b) are met, notwithstanding the provisions of section 408(b)(4) of the Act (relating to investments in bank deposits). However, section 408(b)(6) does not provide an exemption for an act described in section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the assets of the plan). The receipt of such consideration is a separate transaction not described in section 408(b)(6). Section 408(b)(6) does not contain an exemption from other provisions of the Act, such as section 404, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 408(b)(6) of the Act. See, for example, section 401 of the Internal Revenue Code of 1954. The provisions of section 408(b)(6) of the Act are further limited by section 408(d) of the Act (relating to transactions with owner-employees and related persons).

(b) *Conditions.* Such service must be provided—

(1) At not more than reasonable compensation;

(2) Under adequate internal safeguards which assure that the provision of such service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority; and

(3) Only to the extent that such service is subject to specific guidelines issued by the bank or similar financial institution which meet the requirements of § 2550.408b–6(c).

[42 FR 32392, June 24, 1977; 42 FR 36823, July 18, 1977]

§ 2550.408c–2 Compensation for services.

(a) *In general.* Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (the Act) refers to the payment of reasonable compensation by a plan to a party in interest for services rendered to the plan. Section 408(c)(2) of the Act and §§ 2550.408c–2(b)(1) through 2550.408c–2(b)(4) clarify what constitutes reasonable compensation for such services.

(b)(1) *General rule.* Generally, whether compensation is ''reasonable'' under sections 408 (b)(2) and (c)(2) of the Act depends on the particular facts and circumstances of each case.

(2) *Payments to certain fiduciaries.* Under sections 408(b)(2) and 408(c)(2) of

the Act, the term ''reasonable compensation'' does not include any compensation to a fiduciary who is already receiving full-time pay from an employer or association of employers (any of whose employees are participants in the plan) or from an employee organization (any of whose members are participants in the plan), except for the reimbursement of direct expenses properly and actually incurred and not otherwise reimbursed. The restrictions of this paragraph (b)(2) do not apply to a party in interest who is not a fiduciary.

(3) *Certain expenses not direct expenses.* An expense is not a direct expense to the extent it would have been sustained had the service not been provided or if it represents an allocable portion of overhead costs.

(4) *Expense advances.* Under sections 408(b)(2) and 408(c)(2) of the Act, the term ''reasonable compensation,'' as applied to a fiduciary or an employee of a plan, includes an advance to such a fiduciary or employee by the plan to cover direct expenses to be properly and actually incurred by such person in the performance of such person's duties with the plan if:

(i) The amount of such advance is reasonable with respect to the amount of the direct expense which is likely to be properly and actually incurred in the immediate future (such as during the next month); and

(ii) The fiduciary or employee accounts to the plan at the end of the period covered by the advance for the expenses properly and actually incurred.

(5) *Excessive compensation.* Under sections 408(b)(2) and 408(c)(2) of the Act, any compensation which would be considered excessive under 26 CFR 1.162–7 (Income Tax Regulations relating to compensation for personal services which consitutes an ordinary and necessary trade or business expense) will not be ''reasonable compensation.'' Depending upon the facts and circumstances of the particular situation, compensation which is not excessive under 26 CFR 1.162–7 may, nevertheless, not be ''reasonable compensation'' within the meaning of sections 408(b)(2) and 408 (c)(2) of the Act.

[42 FR 32393, June 24, 1977]

§ 2550.408e Statutory exemption for acquisition or sale of qualifying employer securities and for acquisition, sale, or lease of qualifying employer real property.

(a) *General.* Section 408(e) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406(a) and 406(b)(1) and (2) of the Act any acquisition or sale by a plan of qualifying employer securities (as defined in section 407(d)(5) of the Act), or any acquisition, sale or lease by a plan of qualifying employer real property (as defined in section 407(d)(4) of the Act) if certain conditions are met. The conditions are that:

(1) The acquisition, sale or lease must be for adequate consideration (which is defined in paragraph (d) of this section);

(2) No commission may be charged directly or indirectly to the plan with respect to the transaction; and

(3) In the case of an acquisition or lease of qualifying employer real property, or an acquisition of qualifying employer securities, by a plan other than an eligible individual account plan (as defined in section 407(d)(3) of the Act), the acquisition or lease must comply with the requirements of section 407(a) of the Act.

(b) *Acquisition.* For purposes of section 408(e) and this section, an acquisition by a plan of qualifying employer securities or qualifying employer real property shall include, but not be limited to, an acquisition by purchase, by the exchange of plan assets, by the exercise of warrants or rights, by the conversion of a security, by default of a loan where the qualifying employer security or qualifying employer real property was security for the loan, or in connection with the contribution of such securities or real property to the plan. However, an acquisition of a security shall not be deemed to have occurred if a plan acquires the security as a result of a stock dividend or stock split.

(c) *Sale.* For purposes of section 408(e) and this section, a sale of qualifying employer real property or qualifying employer securities shall include any disposition for value.

(d) *Adequate consideration.* For purposes of section 408(e) and this section, adequate consideration means:

(1) In the case of a marketable obligation, a price not less favorable to the plan than the price determined under section 407(e)(1) of the Act; and

(2) In all other cases, a price not less favorable to the plan than the price determined under section 3(18) of the Act.

(e) *Commission.* For purposes of section 408(e) and this section, the term ''commission'' includes any fee, commission or similar charge paid in connection with a transaction, except that the term ''commission'' does not include a charge incurred for the purpose of enabling the appropriate plan fiduciaries to evaluate the desirability of entering into a transaction to which this section would apply, such as an appraisal or investment advisory fee.

[45 FR 51197, Aug. 1, 1980]

§ 2550.412–1 Temporary bonding requirements.

(a) Pending the issuance of permanent regulations with respect to the bonding provisions under section 412 of the Employee Retirement Income Security Act of 1974 (the Act), any plan official, as defined in section 412(a) of the Act, shall be deemed to be in compliance with the bonding requirements of the Act if he or she is bonded under a bond which would have been in compliance with section 13 of the Welfare and Pension Plans Disclosure Act, as amended (the WPPDA), and with the basic bonding requirements of subparts A through E of part 2580, title 29 CFR, and with the prohibition against bonding by parties interested in the plan contained in subpart G of part 2580 of such title, or would be exempt from such bonding requirements because bonding would not be required under the exemption provisions contained in subpart F of part 2580 of such title. Part 2580 of this title incorporates material previously designated as subparts A through E of part 464, subpart B of part 465 and part 485 of this title of the CFR. The requirements which are set forth in the temporary regulations hereby adopted shall be applicable to all employee benefit plans covered by the Act, including those plans which were not covered by the WPPDA. Thus, for example, the regulations so adopted are applicable to plans containing fewer than 26 participants, although such plans were not covered by the WPPDA.

(b) For the purpose of this temporary regulation, any bond or rider thereto obtained by a plan official which contains a reference to the WPPDA will be construed by the Secretary to refer to the Act: *Provided*, That the surety company so agrees.

(c) For the purpose of this regulation,

(1) Any reference to section 13 of the WPPDA or any subsection thereof in the regulations issued under the WPPDA and which are incorporated by reference by this temporary regulation shall be deemed to refer to section 412 of the Act, or the corresponding subsection thereof,

(2) Where the particular phrases set forth in the Act are not identical to the phrases in the WPPDA and the regulations issued pursuant thereto, the phrases appearing in the Act shall be substituted by operation of law, and

(3) Where the phrases are identical but the meaning is different, the meaning given such phrases by the Act shall govern. For example, the phrase ''administrators, officers, and employees of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handle funds or other property of such plan'' which appears in section 13 of the WPPDA and the regulations issued thereunder shall be construed to mean, for purposes of this regulation, ''plan officials'', which is the term appearing in section 412 of the Act, and the terms ''employee welfare benefit plan'' and ''employee pension benefit plan'' shall be given the meaning assigned to them by the Act, and not the meaning set forth in the WPPDA.

(d) The requirements of this temporary regulation, as set forth in paragraphs (a) through (c) of this section, shall remain in effect pending the issuance of permanent regulations by the Secretary.

[40 FR 2203, Jan. 10, 1975. Redesignated at 40 FR 20629, May 12, 1975, as amended at 50 FR 26706, June 28, 1985]

SUBCHAPTER G—ADMINISTRATION AND ENFORCEMENT UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2560—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

Sec.
2560.502–1 Requests for enforcement pursuant to section 502(b)(2).
2560.502c–2 Civil penalties under section 502(c)(2).
2560.502c–5 Civil penalties under section 502(c)(5).
2560.502c–6 Civil penalties under section 502(c)(6).
2560.502i–1 Civil penalties under section 502(i).
2560.503–1 Claims procedure.

AUTHORITY: 29 U.S.C. 1132, 1135, 1194 and Secretary's Order 1–87, 52 FR 13139 (April 21, 1987).

Section 2560.502–1 also issued under 29 U.S.C. 1132(b)(2).

Section 2560.502i–1 also issued under 29 U.S.C. 1132(i).

Section 2560.503–1 also issued under 29 U.S.C. 1133.

§ 2560.502–1 Requests for enforcement pursuant to section 502(b)(2).

(a) *Form, content and filing.* All requests by participants, beneficiaries, and fiduciaries for the Secretary of Labor to exercise his enforcement authority pursuant to section 502(a)(5), 29 U.S.C. 1132(a)(5), with respect to a violation of, or the enforcement of, parts 2 and 3 of title I of the Employee Retirement Income Security Act of 1974 (the Act) shall be in writing and shall contain information sufficient to form a basis for identifying the participant, beneficiary, or fiduciary and the plan involved. All such requests shall be considered filed if they are directed to and received by any office or official of the Department of Labor or referred to and received by any such office or official by any party to whom such writing is directed.

(b) *Consideration.* The Secretary of Labor retains discretion to determine whether any enforcement proceeding should be commenced in the case of any request received pursuant to paragraph (a) of this section, and he may, but shall not be required to, exercise his authority pursuant to section 502(a)(5) of the Act only if he determines that such violation affects, or such enforcement is necessary to protect claims of participants or beneficiaries to benefits under the plan.

[43 FR 50175, Oct. 27, 1978]

§ 2560.502c–2 Civil penalties under section 502(c)(2).

(a) *In general.* (1) Pursuant to the authority granted the Secretary under section 502(c)(2) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator (within the meaning of section 3(16)(A)) of an employee benefit plan (within the meaning of section 3(3) and § 2510.3–1, *et seq.*) for which an annual report is required to be filed under section 101(b)(1) shall be liable for civil penalties assessed by the Secretary under section 502(c)(2) of the Act in each case in which there is a failure or refusal to file the annual report required to be filed under section 101(b)(1).

(2) For purposes of this section, a failure or refusal to file the annual report required to be filed under section 101(b)(1) shall mean a failure or refusal to file, in whole or in part, that information described in section 103 and § 2520.103–1, *et seq.*, on behalf of the plan at the time and in the manner prescribed therefor.

(b) *Amount assessed.* (1) The amount assessed under section 502(c)(2) shall be determined by the Department of Labor, taking into consideration the degree or willfulness of the failure to file the annual report. However, the amount assessed under section 502(c)(2) of the Act shall not exceed $1,000 a day, computed from the date of the administrator's failure or refusal to file the annual report and, except as provided in paragraph (b)(2) of this section, continuing up to the date on which an annual report satisfactory to the Secretary is filed.

(2) If upon receipt of a notice of intent to assess a penalty (as described in

paragraph (c) of this section) the administrator files a statement of reasonable cause for the failure to file, in accordance with paragraph (e) of this section, a penalty shall not be assessed for any day from the date the Department serves the administrator with a copy of such notice until the day after the Department serves notice on the administrator of its determination on reasonable cause and its intention to assess a penalty (as described in paragraph (g) of this section).

(3) For purposes of this paragraph, the date on which the administrator failed or refused to file the annual report shall be the date on which the annual report was due (determined without regard to any extension for filing). An annual report which is rejected under section 104(a)(4) for a failure to provide material information shall be treated as a failure to file an annual report when a revised report satisfactory to the Department is not filed within 45 days of the date of the Department's notice of rejection.

A penalty shall not be assessed under section 502(c)(2) for any day earlier than the day after the date of an administrator's failure or refusal to file the annual report if a revised filing satisfactory to the Department is not submitted within 45 days of the date of the notice of rejection by the Department.

(c) *Notice of intent to assess a penalty*. Prior to the assessment of any penalty under section 502(c)(2), the Department shall provide to the administrator of the plan a written notice indicating the Department's intent to assess a penalty under section 502(c)(2), the amount of such penalty, the period to which the penalty applies, and the reason(s) for the penalty.

(d) *Waiver of assessed penalty*. The Department may waive all or part of the penalty to be assessed under section 502(c)(2) on a showing by the administrator that there was reasonable cause for the failure to file the annual report.

(e) *Showing of reasonable cause*. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have 30 days from the date of the service of notice, as described in paragraph (i) of this section, to file a statement of reasonable cause for the failure to file a complete annual report or why the penalty, as calculated, should not be assessed. A showing of reasonable cause must be made in the form of a written statement setting forth all the facts alleged as reasonable cause. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) *Failure to file a statement of reasonable cause*. Failure of an administrator to file a statement of reasonable cause within the 30 day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(2). Such notice shall then become a final order of the Secretary, within the meaning of § 2570.61(g).

(g) *Notice of the determination on statement of reasonable cause*. (1) The Department, following a review of all the facts alleged in support of a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its intention to waive the penalty, in whole or in part, and/or assess a penalty. If it is the intention of the Department to assess a penalty, the notice shall indicate the amount of the penalty, not to exceed the amount described in paragraph (c) of this section.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to this paragraph indicating the Department's intention to assess a penalty shall become a final order, within the meaning of § 2570.61(g), 30 days after the date of service of the notice.

(h) *Administrative hearing*. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of § 2570.61(g), if, within 30 days from the date of service of the notice, an answer, as defined in § 2570.61(c), is filed in accordance with § 2570.62.

(i) *Service of notice*. (1) Service of notice shall be made either:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of

the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee.

(j) *Liability*. (1) If more than one person is responsible as administrator for the failure to file the annual report, all such persons shall be jointly and severally liable with respect to such failure.

(2) Any person against whom a civil penalty has been assessed under section 502(c)(2) pursuant to a final order, within the meaning of § 2570.61(g), shall be personally liable for the payment of such penalty.

(k) *Cross-reference*. See §§ 2570.60 through 2570.71 of this chapter for procedural rules relating to administrative hearings under section 502(c)(2) of the Act.

[54 FR 26894, June 26, 1989, as amended by 67 FR 777, Jan. 7, 2002]

§ 2560.502c–5 Civil penalties under section 502(c)(5).

(a) *In general*. (1) Pursuant to the authority granted the Secretary under section 502(c)(5) of the Employee Retirement Income Security Act of 1974 Pub.L. 93–406, 88 Stat. 840–52, as amended by Pub. L. 104–191, 101 Stat. 1936) (the Act), the administrator of a multiple employer welfare arrangement (MEWA) (within the meaning of section 3(40)(A) of the Act) that is not a group health plan, and that provides benefits consisting of medical care (within the meaning of section 733(a)(2)), for which a report is required to be filed under section 101(g){h} of the Act and § 2520.101–2, shall be liable for civil penalties assessed by the Secretary under section 502(c)(5) of the Act for each failure or refusal to file a completed report required to be filed under section 101(g){h} and § 2520.101–2. The term ''administrator'' is defined in § 2520.101–2(b).

(2) For purposes of this section, a failure or refusal to file the report required to be filed under section 101(g){h} shall mean a failure or refusal to file, in whole or in part, that information described in section 101(g){h} and § 2520.101–2, on behalf of the MEWA, at the time and in the manner prescribed therefor.

(b) *Amount assessed*—(1) The amount assessed under section 502(c)(5) shall be determined by the Department of Labor, taking into consideration the degree and/or willfulness of the failure to file the report. However, the amount assessed under section 502(c)(5) of the Act shall not exceed $1,000 a day, computed from the date of the administrator's failure or refusal to file the report and, except as provided in paragraph (b)(2) of this section, continuing up to the date on which a report meeting the requirements of section 101(g){h} and § 2520.101–2, as determined by the Secretary, is filed.

(2) If, upon receipt of a notice of intent to assess a penalty (as described in paragraph (c) of this section), the administrator files a statement of reasonable cause for the failure to file, in accordance with paragraph (e) of this section, a penalty shall not be assessed for any day from the date the Department serves the administrator with a copy of such notice until the day after the Department serves notice on the administrator of its determination on reasonable cause and its intention to assess a penalty (as described in paragraph (g) of this section).

(3) For purposes of this paragraph, the date on which the administrator failed or refused to file the report shall be the date on which the report was due (determined without regard to any extension of time for filing). A report which is rejected under § 2520.101–2 shall be treated as a failure to file a report when a revised report meeting the requirements of this section is not filed within 45 days of the date of the Department's notice of rejection. If a revised report meeting the requirements of this section, as determined by the Secretary, is not submitted within 45 days of the date of the notice of rejection by the Department, a penalty shall be assessed under section 502(c)(5) beginning on the day after the date of the administrator's failure or refusal to file the report.

(c) *Notice of intent to assess a penalty*. Prior to the assessment of any penalty under section 502(c)(5), the Department

shall provide to the administrator of the MEWA a written notice indicating the Department's intent to assess a penalty under section 502(c)(5), the amount of such penalty, the period to which the penalty applies, and a statement of the facts and the reason(s) for the penalty.

(d) *Waiver of assessed penalty*. The Department may waive all or part of the penalty to be assessed under section 502(c)(5) on a showing by the administrator that there was reasonable cause for the failure to file the report.

(e) *Showing of reasonable cause*. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have 30 days from the date of the service of notice, as described in paragraph (i) of this section, to file a statement of reasonable cause for the failure to file a complete report or why the penalty, as calculated, should not be assessed. A showing of reasonable cause must be made in the form of a written statement setting forth all the facts alleged as reasonable cause. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) *Failure to file a statement of reasonable cause*. Failure of an administrator to file a statement of reasonable cause within the 30 day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(5). Such notice shall then become a final order of the Secretary, within the meaning of § 2570.91(g).

(g) *Notice of the determination on statement of reasonable cause*—(1) The Department, following a review of all the facts alleged in support of a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its intention to waive the penalty, in whole or in part, and/or assess a penalty. If it is the intention of the Department to assess a penalty, the notice shall indicate the amount of the penalty, not to exceed the amount described in paragraph (c) of this section, and a brief statement of the reasons for assessing the penalty.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to this paragraph indicating the Department's intention to assess a penalty shall become a final order, within the meaning of § 2570.91(g), 30 days after the date of service of the notice.

(h) *Administrative hearing*. A notice issued pursuant to paragraph (g) of this section will become the final order of the Department of Labor, unless, within 30 days from the date of the service of the notice, the administrator or representative thereof files a request for a hearing under § 2570.90 *et seq*., and files and answer to the notice. The request for hearing and answer shall be filed in accordance with § 2570.92. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g).

(i) *Service of notice*—(1) Service of notice shall be made either:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee

(j) *Liability*—(1) If more than one person is responsible as administrator for the failure to file the report, all such persons shall be jointly and severally liable with respect to such failure.

(2) Any person against whom a civil penalty has been assessed under section 502(c)(5) pursuant to a final order, within the meaning of § 2570.91(g), shall be personally liable for the payment of such penalty.

(k) *Cross-reference*. See §§ 2570.90 through 101 of this chapter for procedural rules relating to administrative hearings under section 502(c)(5) of the Act.

(l) *Applicability date*—(1) *In general*. This section applies to administrators

of multiple employer welfare arrangements that are not group health plans beginning May 1, 2000.

(2) *Transitional safe harbor period.* No civil penalty will be assessed against an administrator that has made a good faith effort to comply with a § 2520.101–2 filing that is due in the Year 2000.

[65 FR 7184, Feb. 11, 2000]

§ 2560.502c–6 Civil penalties under section 502(c)(6).

(a) *In general.* (1) Pursuant to the authority granted the Secretary under section 502(c)(6) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator (within the meaning of section 3(16)(A) of the Act) of an employee benefit plan (within the meaning of section 3(3) of the Act and § 2510.3–1 of this chapter) shall be liable for civil penalties assessed by the Secretary under section 502(c)(6) of the Act in each case in which there is a failure or refusal to furnish to the Secretary documents requested under section 104(a)(6) of the Act and § 2520.104a–8 of this chapter.

(2) For purposes of this section, a failure or refusal to furnish documents shall mean a failure or refusal to furnish, in whole or in part, the documents requested under section 104(a)(6) of the Act and § 2520.104a–8 of this chapter at the time and in the manner prescribed in the request.

(b) *Amount assessed.* (1) The amount assessed under section 502(c)(6) of the Act shall be an amount up to $100 a day determined by the Department of Labor, taking into consideration the amount of willfulness of the failure or refusal to furnish the documents requested under section 104(a)(6) of the Act, but in no event in excess of $1,000 per request. Subject to paragraph (b)(2) of this section, the amount shall be computed from the date of the administrator's failure or refusal to furnish any document or documents requested by the Department.

(2) For purposes of calculating the amount to be assessed under this section, the date of a failure or refusal to furnish documents shall not be earlier than the thirtieth day after service of the request under section 104(a)(6) of ERISA and § 2520.104a–8 of this chapter.

(c) *Notice of intent to assess a penalty.* Prior to the assessment of any penalty under section 502(c)(6) of the Act, the Department shall provide to the administrator of the plan a written notice that indicates the Department's intent to assess a penalty under section 502(c)(6) of the Act, the amount of the penalty, the period to which the penalty applies, and the reason(s) for the penalty.

(d) *Waiver of assessed penalty.* The Department may waive all or part of the penalty to be assessed under section 502(c)(6) of the Act on a showing by the administrator that the failure or refusal to furnish a document or documents requested by the Secretary was the result of matters reasonably beyond the administrator's control.

(e) *Statement showing matters reasonably beyond the control of the plan administrator.* Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have 30 days from the date of the service of the notice, as described in paragraph (i) of this section, to file a statement that the failure resulted from matters reasonably beyond the control of the administrator or that the penalty, as calculated, should not be assessed. The statement must be in writing and set forth all the facts alleged as matters reasonably beyond the control of the administrator. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) *Failure to file a statement of matters reasonably beyond the control of the plan administrator.* Failure to file a statement of matters reasonably beyond the control of the administrator within the 30-day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(6) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of § 2570.111(g) of this chapter.

(g) *Notice of determination on statement of matters reasonably beyond the control*

of the plan administrator. (1) The Department, following a review of all of the facts alleged in support of a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its intention to waive the penalty, in whole or in part, and/or assess a penalty. If it is the intention of the Department to assess a penalty, the notice shall indicate the amount of the penalty, not to exceed the amount described in paragraph (b) of this section. This notice is a ''pleading'' for purposes of § 2570.111(m) of this chapter.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) indicating the Department's intention to assess a penalty shall become a final order, within the meaning of § 2570.111(g) of this chapter, 30 days after the date of service of the notice.

(h) *Administrative hearing*. A notice issued pursuant to paragraph (g) of this section will become the final order of the Department of Labor, unless, within 30 days from the date of the service of the notice, the administrator or representative thereof files a request for a hearing under § 2570.110 through § 2570.121 of this chapter, and files an answer to the notice. The request for hearing and answer shall be filed in accordance with § 2570.112 of this chapter. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) *Service of notice*. (1) Service of notice under this section shall be made by:

(i) Delivering a copy to the administrator or representative thereof;

(ii) Leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) Mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee.

(j) *Liability*. (1) If more than one person is responsible as administrator for the failure to furnish the document or documents requested under section 104(a)(6) of the Act and its implementing regulations (§ 2520.104a–8 of this chapter), all such persons shall be jointly and severally liable with respect to such failure.

(2) Any person, or persons under paragraph (j)(1) of this section, against whom a civil penalty has been assessed under section 502(c)(6) of the Act pursuant to a final order, within the meaning of § 2570.111(g) of this chapter, shall be personally liable for the payment of such penalty.

(k) *Cross-reference*. See §§ 2570.110 through 2570.121 of this chapter for procedural rules relating to administrative hearings under section 502(c)(6) of the Act.

[67 FR 785, Jan. 7, 2002]

§ 2560.502i–1 Civil penalties under section 502(i).

(a) *In general*. Section 502(i) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) permits the Secretary of Labor to assess a civil penalty against a party in interest who engages in a prohibited transaction with respect to an employee benefit plan other than a plan described in section 4975(e)(1) of the Internal Revenue Code (the Code). The initial penalty under section 502(i) is five percent of the total ''amount involved'' in the prohibited transaction (unless a lesser amount is otherwise agreed to by the parties). However, if the prohibited transaction is not corrected during the ''correction period,'' the civil penalty shall be 100 percent of the ''amount involved'' (unless a lesser amount is otherwise agreed to by the parties). Paragraph (b) of this section defines the term ''amount involved,'' paragraph (c) defines the term ''correction,'' and paragraph (d) defines the term ''correction period.'' Paragraph (e) illustrates the computation of the civil penalty under section 502(i). Paragraph (f) is a cross reference to the Department's procedural rules for section 502(i) proceedings.

(b) *Amount involved*. Section 502(i) of ERISA states that the term ''amount involved'' in that section shall be defined as it is defined under section 4975(f)(4) of the Code. As provided in 26

CFR 141.4975.13, 26 CFR 53.4941(e)–1(b) is controlling with respect to the interpretation of the term ''amount involved'' under section 4975 of the Code. Accordingly, the Department of Labor will apply the principles set out at 26 CFR 53.4941(e)–1(b) in determining the ''amount involved' in a transaction subject to the civil penalty provided by section 502(i) of the Act and this section.

(c) *Correction*. Section 502(i) of ERISA states that the term ''correction'' shall be defined in a manner that is consistent with the definition of that term under section 4975(f)(5) of the Code. As provided in 26 CFR 141.4975–13, 26 CFR 53.4941(e)–1(c) is controlling with respect to the interpretation of the term ''correction'' for purposes of section 4975 of the Code. Accordingly, the Department of Labor will apply the principles set out in 26 CFR 53.4941(e)–(1)(c) in interpreting the term ''correction'' under section 502(i) of the Act and this section.

(d) *Correction period*. (1) In general, the ''correction period'' begins on the date the prohibited transaction occurs and ends 90 days after a final agency order with respect to such transaction.

(2) When a party in interest seeks judicial review within 90 days of a final agency order in an ERISA section 502(i) proceeding, the correction period will end 90 days after the entry of a final order in the judicial action.

(3) The following examples illustrate the operation of this paragraph:

(i) A party in interest receives notice of the Department's intent to impose the section 502(i) penalty and does not invoke the ERISA section 502(i) prohibited transaction penalty proceedings described in § 2570.1 of this chapter within 30 days of such notice. As provided in § 2570.5 of this chapter, the notice of the intent to impose a penalty becomes a final order after 30 days. Thus, the ''correction period'' ends 90 days after the expiration of the 30 day period.

(ii) A party in interest contests a proposed section 502(i) penalty, but does not appeal an adverse decision of the administrative law judge in the proceeding. As provided in § 2570.10(a) of this chapter, the decision of the administrative law judge becomes a final order of the Department unless the decision is appealed within 20 days after the date of such order. Thus, the correction period ends 90 days after the expiration of such 20 day period.

(iii) The Secretary of Labor issues to a party in interest a decision upholding an administrative law judge's adverse decision. As provided in § 2570.12(b) of this chapter, the decision of the Secretary becomes a final order of the Department immediately. Thus, the correction period will end 90 days after the issuance of the Secretary's order unless the party in interest judicially contests the order within that 90 day period. If the party in interest so contests the order, the correction period will end 90 days after the entry of a final order in the judicial action.

(e) *Computation of the section 502(i) penalty*. (1) In general, the civil penalty under section 502(i) is determined by applying the applicable percentage (five percent or one hundred percent) to the aggregate amount involved in the transaction. However, a continuing prohibited transaction, such as a lease or a loan, is treated as giving rise to a separate event subject to the sanction for each year (as measured from the anniversary date of the transaction) in which the transaction occurs.

(2) The following examples illustrate the computation of the section 502(i) penalty:

(i) An employee benefit plan purchases property from a party in interest at a price of $10,000. The fair market value of the property is $5,000. The ''amount involved'' in that transaction, as determined under 26 CFR 53.4941(e)–1(b), is $10,000 (the greater of the amount paid by the plan or the fair market value of the property). The initial five percent penalty under section 502(i) is $500 (five percent of $10,000).

(ii) An employee benefit plan executes a four year lease with a party in interest at an annual rental of $10,000 (which is the fair rental value of the property). The amount involved in each year of that transaction, as determined under 26 CFR 53.4941(e)–1(b), is $10,000. The amount of the initial sanction under ERISA section 502(i) would be a total of $5,000: $2,000 ($10,000 × 5% × 4 with respect to the rentals paid in the first year of the lease); $1,500 ($10,000 × 5% × 3 with respect to the second year); $1,000 ($10,000 × 5% × 2 with respect to the third year); $500 ($10,000 × 5% × 1 with respect to the fourth year).

(f) *Cross reference*. See §§ 2570.1—2570.12 of this chapter for procedural rules relating to section 502(i) penalty proceedings.

[53 FR 37476, Sept. 26, 1988]

§ 2560.503–1 Claims procedure.

(a) *Scope and purpose.* In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) *Obligation to establish and maintain reasonable claims procedures.* Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102–3;

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (h), (i), and (j) of this section (but will not be deemed to comply with paragraphs (c) through (g) of this section) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) *Group health plans.* The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan's procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory

arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) *Plans providing disability benefits.* The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) *Claim for benefits.* For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) *Timing of notification of benefit determination.* (1) *In general.* Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) *Group health plans.* In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) *Urgent care claims.* In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan's receipt of the specified information, or

(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) *Concurrent care decisions.* If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a

time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) *Other claims*. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan's benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) *Pre-service claims*. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.

(B) *Post-service claims*. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) *Disability claims*. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan,

a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) *Calculating time periods.* For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) *Manner and content of notification of benefit determination.* (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b–1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant —

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) *Appeal of adverse benefit determinations.* (1) *In general.* Every employee

benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) *Full and fair review.* Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) *Group health plans.* The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) *Plans providing disability benefits.* The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims

procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

(i) *Timing of notification of benefit determination on review.* (1) *In general.* (i) Except as provided in paragraphs (i)(1)(ii), (i)(2), and (i)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(1)(i) of this section shall not apply, and, except as provided in paragraphs (i)(2) and (i)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) *Group health plans.* In the case of a group health plan, the plan administrator shall notify a claimant of the plan's benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) *Urgent care claims.* In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

(ii) *Pre-service claims.* In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination.

(iii) *Post-service claims.* (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant's request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) *Disability claims.* (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan's procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) *Calculating time periods.* For purposes of paragraph (i) of this section,

the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) *Furnishing documents.* In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) *Manner and content of notification of benefit determination on review.* The plan administrator shall provide a claimant with written or electronic notification of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b–1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: ''You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.''

(k) *Preemption of State law.* (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) *Failure to establish and follow reasonable claims procedures.* In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) *Definitions.* The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A ''claim involving urgent care'' is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a ''claim involving urgent care'' within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant's medical condition determines is a ''claim involving urgent care'' within the meaning of paragraph (m)(1)(i) of this section shall be treated as a ''claim involving urgent care'' for purposes of this section.

(2) The term ''pre-service claim'' means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term ''post-service claim'' means any claim for a benefit under a group health plan that is not a pre-service claim within the meaning of paragraph (m)(2) of this section.

(4) The term ''adverse benefit determination'' means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term ''notice'' or ''notification'' means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b–1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term ''group health plan'' means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides ''medical care'' within the meaning of section 733(a) of the Act.

(7) The term ''health care professional'' means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered ''relevant'' to a claimant's claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) *Apprenticeship plans*. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) *Applicability dates*. (1) Except as provided in paragraph (o)(2) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.

[65 FR 70265, Nov. 21, 2000, as amended at 66 FR 35887, July 9, 2001]

PART 2570—PROCEDURAL REGULATIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

Subpart A—Procedures for the Assessment of Civil Sanctions Under ERISA Section 502(i)

Sec.
2570.1 Scope of rules.
2570.2 Definitions.
2570.3 Service: Copies of documents and pleadings.
2570.4 Parties.
2570.5 Consequences of default.
2570.6 Consent order or settlement.
2570.7 Scope of discovery.
2570.8 Summary decision.
2570.9 Decision of the administrative law judge.
2570.10 Review by the Secretary.
2570.11 Scope of review.
2570.12 Procedures for review by the Secretary.

Subpart B—Procedures for Filing and Processing Prohibited Transaction Exemption Applications

2570.30 Scope of rules.
2570.31 Definitions.
2570.32 Persons who may apply for exemptions.
2570.33 Applications the Department will not ordinarily consider.
2570.34 Information to be included in every exemption application.
2570.35 Information to be included in applications for individual exemptions only.
2570.36 Where to file an application.
2570.37 Duty to amend and supplement exemption applications.
2570.38 Tentative denial letters.
2570.39 Opportunities to submit additional information.
2570.40 Conferences.
2570.41 Final denial letters.
2570.42 Notice of proposed exemption.
2570.43 Notification of interested persons by applicant.
2570.44 Withdrawal of exemption applications.
2570.45 Requests for reconsideration.
2570.46 Hearings in opposition to exemptions from restrictions on fiduciary self-dealing.
2570.47 Other hearings.
2570.48 Decision to grant exemptions.
2570.49 Limits on the effect of exemptions.
2570.50 Revocation or modification of exemptions.
2570.51 Public inspection and copies.
2570.52 Effective date.

Subpart C—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(2)

2570.60 Scope of rules.
2570.61 Definitions.
2570.62 Service: Copies of documents and pleadings.
2570.63 Parties, how designated.
2570.64 Consequences of default.
2570.65 Consent order or settlement.
2570.66 Scope of discovery.
2570.67 Summary decision.
2570.68 Decision of the administrative law judge.
2570.69 Review by the Secretary.
2570.70 Scope of review.

2570.71 Procedures for review by the Secretary.

Subpart D—Procedure for the Assessment of Civil Penalties Under ERISA Section 502(l)

2570.80 Scope of rules.
2570.81 In general.
2570.82 Definitions.
2570.83 Assessment of civil penalty.
2570.84 Payment of civil penalty.
2570.85 Waiver or reduction of civil penalty.
2570.86 Reduction of penalty by other penalty assessments.
2570.87 Revision of assessment.
2570.88 Effective date.

Subpart E—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(5)

2570.90 Scope of rules.
2570.91 Definitions.
2570.92 Service: Copies of documents and pleadings.
2570.93 Parties, how designated.
2570.94 Consequences of default.
2570.95 Consent order or settlement.
2570.96 Scope of discovery.
2570.97 Summary decision.
2570.98 Decision of the administrative law judge.
2570.99 Review by the Secretary.
2570.100 Scope of review.
2570.101 Procedures for review by the Secretary.

Subpart F—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(6)

2570.110 Scope of rules.
2570.111 Definitions.
2570.112 Service: Copies of documents and pleadings.
2570.113 Parties, how designated.
2570.114 Consequences of default.
2570.115 Consent order or settlement.
2570.116 Scope of discovery.
2570.117 Summary decision.
2570.118 Decision of the administrative law judge.
2570.119 Review by the Secretary.
2570.120 Scope of review.
2570.121 Procedures for review by the Secretary.

AUTHORITY: 29 U.S.C. 1108 (a), 1132 (c), 1132 (i), 1135; 5 U.S.C. 8477(c)(3); Reorganization Plan no. 4 of 1978; Secretary of Labor's Order 1–87.

Subpart A is also issued under 29 U.S.C. 1132(c)(1).

Subpart F is also issued under sec. 4, Pub. L. 101–410, 104 Stat. 890 (28 U.S.C. 2461 note), as amended by sec. 31001(s)(1), Pub. L. 104–134, 110 Stat. 1321–373.

SOURCE: 53 FR 37476, Sept. 26, 1988, unless otherwise noted.

Subpart A—Procedures for the Assessment of Civil Sanctions Under ERISA Section 502(i)

§ 2570.1 Scope of rules.

The rules of practice set forth in this part are applicable to ''prohibited transaction penalty proceedings'' (as defined in § 2570.2(o) of this part) under section 502(i) of the Employee Retirement Income Security Act of 1974. The rules of procedure for administrative hearings published by the Department's Office of Administrative Law Judges at part 18 of this title will apply to matters arising under ERISA section 502(i) except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.2 Definitions.

For prohibited transaction penalty proceedings, this section shall apply in lieu of the definitions in § 18.2 of this title:

(a) *Adjudicatory proceeding* means a judicial-type proceeding leading to the formulation of a final order;

(b) *Administrative law judge* means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) *Answer* is defined for these proceedings as set forth in § 18.5(d)(2) of this title;

(d) *Commencement of proceeding* is the filing of an answer by the respondent;

(e) *Consent agreement* means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) *ERISA* means the Employee Retirement Income Security Act of 1974, as amended;

(g) *Final order* means the final decision or action of the Department of Labor concerning the assessment of a civil sanction under ERISA section 502(i) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, or the failure of a party to

invoke the procedures for hearings or appeals under this title. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(h) *Hearing* means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) *Notice* means any document, however designated, issued by the Department of Labor which initiates an adjudicatory proceeding under ERISA section 502(i);

(j) *Order* means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(i);

(k) *Party* includes a person or agency named or admitted as a party to a proceeding;

(l) *Person* includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(m) *Petition* means a written request, made by a person or party, for some affirmative action;

(n) *Pleading* means the notice, the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(o) *Prohibited transaction penalty proceeding* means a proceeding relating to the assessment of the civil penalty provided for in section 502(i) of ERISA;

(p) *Respondent* means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(i);

(q) *Secretary* means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Pension and Welfare Benefits), administrator, commissioner, appellate body, board, or other official;

(r) *Solicitor* means the Solicitor of Labor or his or her delegate.

§ 2570.3 Service: Copies of documents and pleadings.

For prohibited transaction penalty proceedings, this section shall apply in lieu of § 18.3 of this title.

(a) *General*. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ regional Office to which the proceedings may have been transferred for hearing. Each document filed shall be clear and legible.

(b) *By parties*. All motions, petitions, pleadings, briefs or other documents shall be filed with the Office of Administrative Law Judges with a copy including any attachments to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 502(i) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) *By the Office of Administrative Law Judges*. Service of orders, decisions and all other documents, except notices, shall be made by regular mail to the last known address.

(d) *Service of notices*. (1) Service of notices shall be made either:

(i) By delivering a copy to the individual, any partner, any officer of a corporation, or any attorney of record;

(ii) By leaving a copy at the principal office, place of business, or residence of such individual, partner, officer or attorney; or

(iii) By mailing a copy to the last known address of such individual, partner, officer or attorney.

(2) If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee.

(e) *Form of pleadings*. (1) Every pleading shall contain information indicating the name of the Pension and Welfare Benefits Administration (PWBA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if

any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ × 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopied, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

[53 FR 37476, Sept. 26, 1988, as amended at 65 FR 7191, Feb. 11, 2000]

§ 2570.4 Parties.

For prohibited transaction penalty proceedings, this section shall apply in lieu of § 18.10 of this title.

(a) The term *party* wherever used in these rules shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil sanction is sought shall be designated as ''respondent.'' The Department shall be designated as the ''complainant.''

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner's interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petititioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.5 Consequences of default.

For prohibited transaction penalty proceedings, this section shall apply in lieu of § 18.5(b) of this title. Failure of the respondent to file an answer within the 30 day time period provided in § 18.5 of this title shall be deemed to constitute a waiver of his right to appear and contest the allegations of the notice, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of the prohibited transaction penalty proceeding. Such notice shall then become the final order of the Secretary, except that the administrative law judge may set aside a default entered under this

provision where there is proof of defective notice.

§ 2570.6 Consent order or settlement.

For prohibited transaction penalty proceedings, the following shall apply in lieu of § 18.9 of this title.

(a) *General.* At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such deferment and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) *Content.* Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and

(5) That the order and decision of the administrative law judge shall be final agency action.

(c) *Submission.* On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) *Disposition.* In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within thirty (30) days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) *Settlement without consent of all parties.* In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the

consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.7 Scope of discovery.

For prohibited transaction penalty proceedings, this section shall apply in lieu of § 18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish ''good cause'' for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which ''good cause'' has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party's representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon a showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the proceeding.

§ 2570.8 Summary decision.

For prohibited transaction penalty proceedings, this section shall apply in lieu of § 18.41 of this title.

(a) *No genuine issue of material fact.* (1) Where no genuine issue of a material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§ 2570.10–2570.12 of this part, shall become a final order.

(2) A decision made under this paragraph shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) *Hearings on issue of fact.* Where a genuine question of material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.9 Decision of the administrative law judge.

For prohibited transaction penalty proceedings, this section shall apply in lieu of § 18.57 of this title

(a) *Proposed findings of fact, conclusions, and order.* Within twenty (20) days of the filing of the transcript of the testimony or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and brief shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) *Decision of the administrative law judge.* Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefor upon each material issue of fact of law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for prohibited transaction penalty proceedings as

set forth in this part, the penalty (if any) which may be included in the decision of the administrative law judge shall be limited to the sanction expressly provided for in section 502(i) of ERISA. It shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§ 2570.10 through 2570.12.

§ 2570.10 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him a copy of the entire record before the administrative law judge.

§ 2570.11 Scope of review.

The review of the Secretary shall not be a *de novo* proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.12 Procedures for review by the Secretary.

(a) Upon receipt of a notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart B—Procedures for Filing and Processing Prohibited Transaction Exemption Applications

SOURCE: 55 FR 32847, Aug. 10, 1990, unless otherwise noted.

§ 2570.30 Scope of rules.

(a)(1) The rules of procedure set forth in this subpart apply to all applications for exemption which the Department has authority to issue under:

(i) Section 408(a) of the Employee Retirement Income Security Act of 1974 (ERISA);

(ii) Section 4975(c)(2) of the Internal Revenue Code of 1986 (the Code) (see Reorganization Plan No. 4 of 1978); or

(iii) The Federal Employees' Retirement System Act of 1986 (FERSA) (5 U.S.C. 8477(c)(3)).

(b) The Department will generally treat any exemption application which is filed solely under section 408(a) of ERISA or solely under section 4975(c)(2) of the Code as an exemption filed under both section 408(a) and section 4975(c)(2) if it relates to a transaction that would be prohibited both by ERISA and by the corresponding provisions of the Code.

(c) The procedures set forth in this subpart represent the exclusive means by which the Department will issue administrative exemptions. The Department will not issue exemptions upon oral request alone. Likewise, the Department will not grant exemptions orally. An applicant for an administrative exemption may request and receive oral advice from Department employees in preparing an exemption application. However, such advice does not constitute part of the administrative record and is not binding on the Department in its processing of an exemption application or in its examination or audit of a plan.

§ 2570.31 Definitions.

For purposes of these procedures, the following definitions apply:

(a) An *affiliate* of a person means—

(1) Any person directly or indirectly through one or more intermediaries, controlling, controlled by, or under common control with the person;

(2) Any director of, relative of, or partner in, any such person;

(3) Any corporation, partnership, trust, or unincorporated enterprise of which such person is an officer, director, or a 5 percent or more partner or owner; and

(4) Any employee or officer of the person who—

(i) Is highly compensated (as defined in section 4975(e)(2)(H) of the Code), or

(ii) Has direct or indirect authority, responsibility, or control regarding the custody, management, or disposition of plan assets.

(b) A *class exemption* is an administrative exemption, granted under section 408(a) of ERISA, section 4975(c)(2) of the Code, and/or 5 U.S.C. 8477(c)(3), which applies to any parties in interest within the class of parties in interest specified in the exemption who meet the conditions of the exemption.

(c) *Department* means the U.S. Department of Labor and includes the Secretary of Labor or his delegate exercising authority with respect to prohibited transaction exemptions to which this subpart applies.

(d) *Exemption transaction* means the transaction or transactions for which an exemption is requested.

(e) An *individual exemption* is an administrative exemption, granted under section 408(a) of ERISA, section 4975(c)(2) of the Code, and/or 5 U.S.C. 8477(c)(3), which applies only to the specific parties in interest named or otherwise defined in the exemption.

(f) A *party in interest* means a person described in section 3(14) of ERISA or 5 U.S.C. 8477(a)(4) and includes a *disqualified person*, as defined in section 4975(e)(2) of the Code.

(g) *Pooled fund* means an account or fund for the collective investment of the assets of two or more unrelated plans, including (but not limited to) a pooled separate account maintained by an insurance company and a common or collective trust fund maintained by a bank or similar financial institution.

§ 2570.32 Persons who may apply for exemptions.

(a) The Department may initiate exemption proceedings on its own motion. In addition, the Department will initiate exemption proceedings upon the application of:

(1) Any party in interest to a plan who is or may be a party to the exemption transaction;

(2) Any plan which is a party to the exemption transaction; or

(3) In the case of an application for an exemption covering a class of parties in interest or a class of transactions, in addition to any person described in paragraphs (a)(1) and (a)(2) of this section, an association or organization representing parties in interest who may be parties to the exemption transaction.

(b) An application by or for a person described in paragraph (a) of this section, may be submitted by the applicant or by his authorized representatives. If the application is submitted by a representative of the applicant, the representative must submit proof of his authority in the form of:

(1) A power of attorney; or

(2) A written certification from the applicant that the representation is authorized.

(c) If the authorized representative of an applicant submits an application for an exemption to the Department together with proof of his authority to file the application as required by paragraph (b) of this section, the Department will direct all correspondence and inquiries concerning the application to the representative unless requested to do otherwise by the applicant.

§ 2570.33 Applications the Department will not ordinarily consider.

(a) The Department will not ordinarily consider:

(1) An application that fails to include all the information required by §§ 2570.34 and 2570.35 or otherwise fails to conform to the requirements of these procedures; or

(2) An application for exemption involving a transaction or transactions

which are the subject of an investigation for possible violations of part 1 or 4 of subtitle B of title I of ERISA or section 8477 or 8478 of FERSA or an application for an exemption involving a party in interest who is the subject of such an investigation or who is a defendant in an action by the Department or the Internal Revenue Service to enforce the above-mentioned provisions of ERISA or FERSA.

(b) If for any reason the Department decides not to consider an exemption application, it will inform the applicant of that decision in writing and of the reasons therefor.

(c) An application for an individual exemption relating to a specific transaction or transactions will ordinarily not be considered separately if the Department is considering a class exemption relating to the same type of transaction or transactions.

§ 2570.34 Information to be included in every exemption application.

(a) All applications for exemptions must contain the following information:

(1) The name(s) of the applicant(s);

(2) A detailed description of the exemption transaction and the parties in interest for whom an exemption is requested, including a description of any larger integrated transaction of which the exemption transaction is a part;

(3) Whether the affected plan(s) and any parties in interest will be represented by the same person with regard to the exemption application;

(4) Reasons a plan would have for entering into the exemption transaction;

(5) The prohibited transaction provisions from which exemptive relief is requested and the reason why the transaction would violate each such provision;

(6) Whether the exemption transaction is customary for the industry or class involved;

(7) Whether the exemption transaction is or has been the subject of an investigation or enforcement action by the Department or by the Internal Revenue Service; and

(8) The hardship or economic loss, if any, which would result to the person or persons on behalf of whom the exemption is sought, to affected plans, and to their participants and beneficiaries from denial of the exemption.

(b) All applications for exemption must also contain the following:

(1) A statement explaining why the requested exemption would be—

(i) Administratively feasible;

(ii) In the interests of affected plans and their participants and beneficiaries; and

(iii) Protective of the rights of participants and beneficiaries of affected plans.

(2) With respect to the notification of interested persons required by § 2570.43:

(i) A description of the interested persons to whom the applicant intends to provide notice;

(ii) The manner in which the applicant will provide such notice; and

(iii) An estimate of the time the applicant will need to furnish notice to all interested persons following publication of a notice of the proposed exemption in the FEDERAL REGISTER.

(3) If an advisory opinion has been requested with respect to any issue relating to the exemption transaction—

(i) A copy of the letter concluding the Department's action on the advisory opinion request; or

(ii) If the Department has not yet concluded its action on the request:

(A) A copy of the request or the date on which it was submitted together with the Department's correspondence control number as indicated in the acknowledgment letter; and

(B) An explanation of the effect of a favorable advisory opinion upon the exemption transaction.

(4) If the application is to be signed by anyone other than an individual party in interest seeking exemptive relief on his own behalf, a statement which—

(i) Identifies the individual who will be signing the application and his position with the applicant; and

(ii) Explains briefly the basis of his familiarity with the matters discussed in the application.

(5)(i) A declaration in the following form:

Under penalty of perjury, I declare that I am familiar with the matters discussed in this application and, to the best of my knowledge and belief, the representations

made in this application are true and correct.

(ii) This declaration must be dated and signed by:

(A) The applicant himself in the case of an individual party in interest seeking exemptive relief on his own behalf;

(B) A corporate officer or partner where the applicant is a corporation or partnership;

(C) A designated officer or official where the applicant is an association, organization or other unincorporated enterprise;

(D) The plan fiduciary who has the authority, responsibility, and control with respect to the exemption transaction where the applicant is a plan.

(iii) Specialized statements from third-party experts, such as appraisals or analyses of market conditions, submitted to support an application for exemption must also be accompanied by a statement of consent from such expert acknowledging that he or she knows that his or her statement is being submitted to the Department as part of an application for exemption.

(iv) For those applications requiring an independent fiduciary to represent the plan in the exemption transaction, each statement submitted by said independent fiduciary must contain a signed and dated declaration under penalty of perjury that, to the best of said fiduciary's knowledge and belief, the representations made in such statement are true and correct.

(c) An application for exemption may also include a draft of the requested exemption which defines the transaction and parties in interest for which exemptive relief is sought and the specific conditions under which the exemption would apply.

§ 2570.35 Information to be included in applications for individual exemptions only.

(a) Except as provided in paragraph (c) of this section, every application for an individual exemption must include, in addition to the information specified in § 2570.34, the following information:

(1) The name, address, telephone number, and type of plan or plans to which the requested exemption applies;

(2) The Employer Identification Number (EIN) and the plan number (PN) used by such plan or plans in all reporting and disclosure required by the Department;

(3) Whether any plan or trust affected by the requested exemption has ever been found by the Department, the Internal Revenue Service, or by a court to have violated the exclusive benefit rule of section 401(a) of the Code, or to have engaged in a prohibited transaction under section 503(b) of the Code or corresponding provisions of prior law, section 4975(c)(1) of the Code, section 406 or 407(a) of ERISA, or 5 U.S.C. 8477(c)(3);

(4) Whether any relief under section 408(a) of ERISA, section 4975(c)(2) of the Code, or 5 U.S.C. 8477(c)(3) has been requested by, or provided to, the applicant or any of the parties on behalf of whom the exemption is sought and, if so, the exemption application number or the prohibited transaction exemption number;

(5) Whether the applicant or any of the parties in interest involved in the exemption transaction is currently, or has been within the last five years, a defendant in any lawsuit or criminal action concerning such person's conduct as a fiduciary or party in interest with respect to any plan;

(6) Whether the applicant or any of the parties in interest involved in the exemption transaction has, within the last 13 years, been convicted of any crime described in section 411 of ERISA;

(7) Whether, within the last five years, any plan affected by the exemption transaction or any party in interest involved in the exemption transaction has been under investigation or examination by, or has been engaged in litigation or a continuing controversy with, the Department, the Internal Revenue Service, the Justice Department, the Pension Benefit Guaranty Corporation, or the Federal Retirement Thrift Investment Board involving compliance with provisions of ERISA, provisions of the Code relating to employee benefit plans, or provisions of FERSA relating to the Federal Thrift Savings Fund. If so, the applicant must submit copies of all correspondence with the Department, the Internal Revenue Service, the Justice Department,

the Pension Benefit Guaranty Corporation, or the Federal Retirement Thrift Investment Board regarding the substantive issues involved in the investigation, examination, litigation, or controversy which relate to compliance with the provisions of part 1 or 4 of subtitle B of title I of ERISA, section 4975 of the Code, or section 8477 or 8478 of FERSA. For this purpose, the term ''examination'' does not include routine audits conducted by the Department pursuant to section 8477(g) of FERSA;

(8) Whether any plan affected by the requested exemption has experienced a reportable event under section 4043 of ERISA;

(9) Whether a notice of intent to terminate has been filed under section 4041 of ERISA respecting any plan affected by the requested exemption;

(10) Names, addresses, and taxpayer identifying numbers of all parties in interest involved in the subject transaction;

(11) The estimated number of participants and beneficiaries in each plan affected by the requested exemption as of the date of the application;

(12) The percentage of the fair market value of the total assets of each affected plan that is involved in the exemption transaction;

(13) Whether the exemption transaction has been consummated or will be consummated only if the exemption is granted;

(14) If the exemption transaction has already been consummated:

(i) The circumstances which resulted in plan fiduciaries causing the plan(s) to engage in the subject transaction before obtaining an exemption from the Department;

(ii) Whether the transaction has been terminated;

(iii) Whether the transaction has been corrected as defined in Code section 4975(f)(5);

(iv) Whether Form 5330, Return of Excise Taxes Related to Employee Benefit Plans, has been filed with the Internal Revenue Service with respect to the transaction; and

(v) Whether any excise taxes due under section 4975(a) and (b) of the Code by reason of the transaction have been paid.

(15) The name of every person who has investment discretion over any assets involved in the exemption transaction and the relationship of each such person to the parties in interest involved in the exemption transaction and the affiliates of such parties in interest;

(16) Whether or not the assets of the affected plan(s) are invested in loans to any party in interest involved in the exemption transaction, in property leased to any such party in interest, or in securities issued by any such party in interest, and, if such investments exist, a statement for each of these three types of investments which indicates:

(i) The type of investment to which the statement pertains;

(ii) The aggregate fair market value of all investments of this type as reflected in the plan's most recent annual report;

(iii) The approximate percentage of the fair market value of the plan's total assets as shown in such annual report that is represented by all investments of this type; and

(iv) The statutory or administrative exemption covering these investments, if any.

(17) The approximate aggregate fair market value of the total assets of each affected plan;

(18) The person(s) who will bear the costs of the exemption application and of notifying interested persons; and

(19) Whether an independent fiduciary is or will be involved in the exemption transaction and, if so, the names of the persons who will bear the cost of the fee payable to such fiduciary.

(b) Each application for an individual exemption must also include:

(1) True copies of all contracts, deeds, agreements, and instruments, as well as relevant portions of plan documents, trust agreements, and any other documents bearing on the exemption transaction;

(2) A discussion of the facts relevant to the exemption transaction that are reflected in these documents and an analysis of their bearing on the requested exemption; and

(3) A copy of the most recent financial statements of each plan affected by the requested exemption.

(c) *Special rule for applications for individual exemption involving pooled funds.* (1) The information required by paragraphs (a)(8) through (12) of this section is not required to be furnished in an application for individual exemption involving one or more pooled funds;

(2) The information required by paragraphs (a)(1) through (7) and (a)(13) through (19) of this section and by paragraphs (b)(1) through (3) of this section must be furnished by reference to the pooled fund, rather than to the plans participating therein. (For purposes of this paragraph, the information required by paragraph (a)(16) of this section relates solely to other pooled fund transactions with, and investments in, parties in interest involved in the exemption transaction which are also sponsors of plans which invest in the pooled fund.);

(3) The following information must also be furnished—

(i) The estimated number of plans that are participating (or will participate) in the pooled fund; and

(ii) The minimum and maximum limits imposed by the pooled fund (if any) on the portion of the total assets of each plan that may be invested in the pooled fund.

(4) Additional requirements for applications for individual exemption involving pooled funds in which certain plans participate.

(i) This paragraph applies to any application for individual exemption involving one or more pooled funds in which any plan participating therein—

(A) Invests an amount which exceeds 20% of the total assets of the pooled fund, or

(B) Covers employees of:

(*1*) The party sponsoring or maintaining the pooled fund, or any affiliate of such party, or

(*2*) Any fiduciary with investment discretion over the pooled fund's assets, or any affiliate of such fiduciary.

(ii) The exemption application must include, with respect to each plan described in paragraph (c)(4)(i) of this section, the information required by paragraphs (a)(1) through (3), (a)(5) through (7), (a)(10), (a)(12) through (16) and, (a)(18) and (19), of this section. The information required by this paragraph must be furnished by reference to the plan's investment in the pooled fund (e.g., the names, addresses and taxpayer identifying numbers of all fiduciaries responsible for the plan's investment in the pooled fund [§ 2570.35(a)(10)], the percentage of the assets of the plan invested in the pooled fund [§ 2570.35(a)(12)], whether the plan's investment in the pooled fund has been consummated or will be consummated only if the exemption is granted [§ 2570.35(a)(13)], etc.).

(iii) The information required by paragraph (c)(4) of this section is in addition to the information required by paragraphs (c)(2) and (3) of this section relating to information furnished by reference to the pooled fund.

(5) The special rule and the additional requirements described in paragraphs (c)(1) through (4) of this section do not apply to an individual exemption request solely for the investment by a plan in a pooled fund. Such an application must provide the information required by paragraphs (a) and (b) of this section.

[55 FR 32847, Aug. 10, 1990; 56 FR 14861, Apr. 12, 1991]

§ 2570.36 Where to file an application.

The Department's prohibited transaction exemption program is administered by the Pension and Welfare Benefits Administration (PWBA). Any exemption application governed by these procedures should be mailed or otherwise delivered to: Exemption Application, PWBA, Office of Exemption Determinations, Division of Exemptions, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210.

§ 2570.37 Duty to amend and supplement exemption applications.

(a) During the pendency of his exemption application, an applicant must promptly notify the Division of Exemptions in writing if he discovers that any material fact or representation contained in his application or in any documents or testimony provided in

support of the application is inaccurate, if any such fact or representation changes during this period, or if, during the pendency of the application, anything occurs that may affect the continuing accuracy of any such fact or representation.

(b) If, at any time during the pendency of his exemption application, an applicant or any other party in interest who would participate in the exemption transaction becomes the subject of an investigation or enforcement action by the Department, the Internal Revenue Service, the Justice Department, the Pension Benefit Guaranty Corporation, or the Federal Retirement Thrift Investment Board involving compliance with provisions of ERISA, provisions of the Code relating to employee benefit plans, or provisions of FERSA relating to the Federal Thrift Savings Fund, the applicant must promptly notify the Division of Exemptions.

(c) The Department may require an applicant to provide documentation it considers necessary to verify any statements contained in the application or in supporting materials or documents.

§ 2570.38 Tentative denial letters.

(a) If, after reviewing an exemption file, the Department concludes that it will not grant the exenption, it will notify the applicant in writing of its tentative denial of the exemption application. At the same time, the Department will provide a short statement of the reasons for its tentative denial.

(b) An applicant will have 20 days from the date of a tentative denial letter to request a conference under § 2570.40 of these procedures and/or to notify the Department of its intent to submit additional information in writing under § 2570.39 of these procedures. If the Department does not receive a request for a conference or a notification of intent to submit additional information within that time, it will issue a final denial letter pursuant to § 2570.41.

(c) The Department need not issue a tentative denial letter to an applicant before issuing a final denial letter where the Department has conducted a hearing on the exemption pursuant to either § 2570.46 or § 2570.47 of these procedures.

§ 2570.39 Opportunities to submit additional information.

(a) An applicant may notify the Department of its intent to submit additional information supporting an exemption application either by telephone or by letter sent to the address furnished in the applicant's tentative denial letter. At the same time, the applicant should indicate generally the type of information that he will submit.

(b) An applicant will have 30 days from the date of the notification discussed in paragraph (a) of this section to submit in writing all of the additional information he intends to provide in support of his application. All such information must be accompanied by a declaration under penalty of perjury attesting to the truth and correctness of the information provided, which is dated and signed by a person qualified under § 2570.34(b)(5) of these procedures to sign such a declaration.

(c) If, for reasons beyond his control, an applicant is unable to submit in writing all the additional information he intends to provide in support of his application within the 30-day period described in paragraph (b) of this section, he may request an extension of time to furnish the information. Such requests must be made before the expiration of the 30-day period and will be granted only in unusual circumstances and for limited periods of time.

(d) If an applicant is unable to submit all of the additional information he intends to provide in support of his exemption application within the 30-day period specified in paragraph (b) of this section, or within any additional period of time granted to him pursuant to paragraph (c) of this section, the applicant may withdraw the exemption application before expiration of the applicable time period and reinstate it later pursuant to § 2570.44 of these procedures.

(e) The Department will issue, without further notice, a final denial letter denying the requested exemption pursuant to § 2570.41 of these procedures where—

(1) The Department has not received the additional information that the applicant indicated he would submit within the 30-day period described in paragraph (b) of this section, or within any additional period of time granted pursuant to paragraph (c) of this section;

(2) The applicant did not request a conference pursuant to § 2570.38(b) of these procedures; and

(3) The applicant has not withdrawn his application as permitted by paragraph (d) of this section.

§ 2570.40 Conferences.

(a) Any conference between the Department and an applicant pertaining to a requested exemption will be held in Washington, DC, except that a telephone conference will be held at the applicant's request.

(b) An applicant is entitled to only one conference with respect to any exemption application. An applicant will not be entitled to a conference, however, where the Department has held a hearing on the exemption under either § 2570.46 or § 2570.47 of these procedures.

(c) Insofar as possible, conferences will be scheduled as joint conferences with all applicants present where:

(1) More than one applicant has requested an exemption with respect to the same or similar types of transactions;

(2) The Department is considering the applications together as a request for a class exemption;

(3) The Department contemplates not granting the exemption; and

(4) More than one applicant has requested a conference.

(d) The Department will attempt to schedule a conference under this section for a mutually convenient time during the 45-day period following the later of—

(1) The date the Department receives the applicant's request for a conference, or

(2) The date the Department notifies the applicant, after reviewing additional information submitted pursuant to § 2570.39, that it is still not prepared to propose the requested exemption.

If the applicant is unable to attend a conference at any of the times proposed by the Department during this 45-day period or if the applicant fails to appear for a scheduled conference, he will be deemed to have waived his right to a conference unless circumstances beyond his control prevent him from scheduling a conference or attending a scheduled conference within this period.

(e) Within 20 days after the date of any conference held under this section, the applicant may submit to the Department a written record of any additional data, arguments, or precedents discussed at the conference but not previously or adequately presented in writing.

§ 2570.41 Final denial letters.

(a) The Department will issue a final denial letter denying a requested exemption where:

(1) The conditions for issuing a final denial letter specified in § 2570.38(b) or § 2570.39(e) of these procedures are satisfied;

(2) After issuing a tentative denial letter under § 2570.38 of this part and considering the entire record in the case, including all written information submitted pursuant to § 2570.39 and § 2570.40(e) of these procedures, the Department decides not to propose an exemption or to withdraw an exemption already proposed; or

(3) After proposing an exemption and conducting a hearing on the exemption under either § 2570.46 or § 2570.47 of this part and after considering the entire record in the case, including the record of the hearing, the Department decides to withdraw the proposed exemption.

(b) [Reserved]

§ 2570.42 Notice of proposed exemption.

If the Department tentatively decides, based on all the information submitted by an applicant, that the exemption should be granted, it will publish a notice of proposed exemption in the FEDERAL REGISTER. The notice will:

(a) Explain the exemption transaction and summarize the information received by the Department in support of the exemption;

(b) Specify any conditions under which the exemption is proposed;

(c) Inform interested persons of their right to submit comments in writing to the Department relating to the proposed exemption and establish a deadline for receipt of such comments;

(d) If the proposed exemption includes relief from the prohibitions of section 406(b) of ERISA, section 4975(c)(1)(E) or (F) of the Code, or section 8477(c)(2) of FERSA, inform interested persons of their right to request a hearing under § 2570.46 of this part and establish a deadline for receipt of requests for such hearings.

§ 2570.43 Notification of interested persons by applicant.

(a) If, as set forth in the exemption application, the notification that an applicant intends to provide to interested persons upon publication of a notice of proposed exemption in the FEDERAL REGISTER is inadequate, the Department will so inform the applicant and will secure the applicant's written agreement to provide what it considers to be adequate notice under the circumstances.

(b) If a notice of proposed exemption is published in the FEDERAL REGISTER in accordance with § 2570.42 of this part, the applicant must notify interested persons of the pendency of the exemption in the manner and time period specified in the application or in any superseding agreement with the Department. Any such notification must include:

(1) A copy of the notice of proposed exemption; and

(2) A supplemental statement in the following form:

You are hereby notified that the United States Department of Labor is considering granting an exemption from the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, or the Federal Employees' Retirement System Act of 1986. The exemption under consideration is explained in the enclosed Notice of Proposed Exemption. As a person who may be affected by this exemption, you have the right to comment on the proposed exemption by [date].[1] [If you may be adversely affected by the grant of the exemption, you also have the right to request a hearing on the exemption by [date].][2]

Comments or requests for a hearing should be addressed to: Office of Exemption Determinations, Pension and Welfare Benefits Administration, room _____,[3] U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, ATTENTION: Application No. _____.[4]

The Department will make no final decision on the proposed exemption until it reviews all comments received in response to the enclosed notice. If the Department decides to hold a hearing on the exemption before making its final decision, you will be notified of the time and place of the hearing.

(c) The method used to furnish notice to interested persons must be reasonably calculated to ensure that interested persons actually receive the notice. In all cases, personal delivery and delivery by first-class mail will be considered reasonable methods of furnishing notice.

(d) After furnishing the notice required by this section, an applicant must provide the Department with a statement confirming that notice was furnished to the persons and in the manner and time designated in its exemption application or in any superseding agreement with the Department. This statement must be accompanied by a declaration under penalty of perjury attesting to the truth of the information provided in the statement and signed by a person qualified under § 2570.34(b)(5) of these procedures to sign such a declaration. No exemption will be granted until such a statement and its accompanying declaration have been furnished to the Department.

§ 2570.44 Withdrawal of exemption applications.

(a) An applicant may withdraw his application for an exemption at any

[1] The applicant will write in this space the date of the last day of the time period specified in the notice of proposed exemption.

[2] To be added in the case of an exemption that provides relief from section 406(b) of ERISA or corresponding sections of the Code or FERSA.

[3] The applicant will fill in the room number of the Division of Exemptions. As of the date of this final regulation, the room number of the Division of Exemptions was N–5671.

[4] The applicant will fill in the exemption application number, which is stated in the notice of proposed exemption, as well as in all correspondence from the Department to the applicant regarding the application.

time by informing the Department, either orally or in writing, of his intent to withdraw.

(b) Upon receiving an applicant's notice of intent to withdraw an application for an individual exemption, the Department will confirm by letter the applicant's withdrawal of the application and will terminate all proceedings relating to the application. If a notice of proposed exemption has been published in the FEDERAL REGISTER, the Department will publish a notice withdrawing the proposed exemption.

(c) Upon receiving an applicant's notice of intent to withdraw an application for a class exemption or for an individual exemption that is being considered with other applications as a request for a class exemption, the Department will inform any other applicants for the exemption of the withdrawal. The Department will continue to process other applications for the same exemption. If all applicants for a particular class exemption withdraw their applications, the Department may either terminate all proceedings relating to the exemption or propose the exemption on its own motion.

(d) If, following the withdrawal of an exemption application, an applicant decides to reapply for the same exemption, he may submit a letter to the Department requesting that the application be reinstated and referring to the application number assigned to the original application. If, at the time the original application was withdrawn, any additional information to be submitted to the Department under § 2570.39 of these procedures was outstanding, that information must accompany the letter requesting reinstatement of the application. However, the applicant need not resubmit information previously furnished to the Department in connection with a withdrawn application unless reinstatement of the application is requested more than two years after the date of its withdrawal.

(e) Any request for reinstatement of a withdrawn application submitted in accordance with paragraph (d) of this section, will be granted by the Department, and the Department will take whatever steps remained at the time the application was withdrawn to process the application.

§ 2570.45 Requests for reconsideration.

(a) The Department will entertain one request for reconsideration of an exemption application that has been finally denied pursuant to § 2570.41 (a)(2) or (a)(3) of this part if the applicant presents in support of the application significant new facts or arguments, which, for good reason, could not have been submitted for the Department's consideration during its initial review of the exemption application.

(b) A request for reconsideration of a previously denied application must be made within 180 days after the issuance of the final denial letter and must be accompanied by a copy of the Department's final letter denying the exemption and a statement setting forth the new information and/or arguments that provide the basis for reconsideration.

(c) A request for reconsideration must also be accompanied by a declaration under penalty of perjury attesting to the truth of the new information provided, which is signed by a person qualified under § 2570.34(b)(5) of these procedures to sign such a declaration.

(d) If, after reviewing a request for reconsideration, the Department decides that the facts and arguments presented do not warrant reversal of its original decision to deny the exemption, it will send a letter to the applicant reaffirming that decision.

(e) If, after reviewing a request for reconsideration, the Department decides, based on the new facts and arguments submitted, to reconsider its denial letter, it will notify the applicant of its intent to reconsider the application in light of the new information presented. The Department will then take whatever steps remained at the time it issued its final denial letter to process the exemption application.

(f) If, at any point during its subsequent processing of the application, the Department decides again that the exemption is unwarranted, it will issue a letter affirming its final denial.

§ 2570.46 Hearings in opposition to exemptions from restrictions on fiduciary self-dealing.

(a) Any interested person who may be adversely affected by an exemption which the Department proposes to grant from the restrictions of section 406(b) of ERISA, section 4975(c)(1)(E) or (F) of the Code, or section 8477(c)(2) of FERSA may request a hearing before the Department within the period of time specified in the FEDERAL REGISTER notice of the proposed exemption. Any such request must state:

(1) The name, address, and telephone number of the person making the request;

(2) The nature of the person's interest in the exemption and the manner in which the person would be adversely affected by the exemption; and

(3) A statement of the issues to be addressed and a general description of the evidence to be presented at the hearing.

(b) The Department will grant a request for a hearing made in accordance with paragraph (a) of this section where a hearing is necessary to fully explore material factual issues identified by the person requesting the hearing. However, the Department may decline to hold a hearing where:

(1) The request for the hearing does not meet the requirements of paragraph (a);

(2) The only issues identified for exploration at the hearing are matters of law; or

(3) The factual issues identified can be fully explored through the submission of evidence in written form.

(c) An applicant for an exemption must notify interested persons in the event that the Department schedules a hearing on the exemption. Such notification must be given in the form, time, and manner prescribed by the Department. Ordinarily, however, adequate notification can be given by providing to interested persons a copy of the notice of hearing published by the Department in the FEDERAL REGISTER within 10 days of its publication, using any of the methods approved in § 2570.43(c) of this part.

(d) After furnishing the notice required by paragraph (c) of this section, an applicant must submit a statement confirming that notice was given in the form, manner, and time prescribed. This statement must be accompanied by a declaration under penalty of perjury attesting to the truth of the information provided in the statement, which is signed by a person qualified under § 2570.34(b)(5) of these procedures to sign such a declaration.

§ 2570.47 Other hearings.

(a) In its discretion, the Department may schedule a hearing on its own motion where it determines that issues relevant to the exemption can be most fully or expeditiously explored at a hearing.

(b) An applicant for an exemption must notify interested persons of any hearing on an exemption scheduled by the Department in the manner described in § 2570.46(c). In addition, the applicant must submit a statement subscribed as true under penalty of perjury like that required in § 2570.46(d).

§ 2570.48 Decision to grant exemptions.

(a) If, after considering all the facts and representations submitted by an applicant in support of an exemption application, all the comments received in response to a notice of proposed exemption, and the record of any hearing held in connection with the proposed exemption, the Department determines that the exemption should be granted, it will publish a notice in the FEDERAL REGISTER granting the exemption.

(b) A FEDERAL REGISTER notice granting an exemption will summarize the transaction or transactions for which exemptive relief has been granted and will specify the conditions under which such exemptive relief is available.

§ 2570.49 Limits on the effect of exemptions.

(a) An exemption does not take effect or protect parties in interest from liability with respect to the exemption transaction unless the material facts and representations contained in the application and in any materials and documents submitted in support of the application were true and complete.

(b) An exemption is effective only for the period of time specified and only

under the conditions set forth in the exemption.

(c) Only the specific parties to whom an exemption grants relief may rely on the exemption. If the notice granting an exemption does not limit exemptive relief to specific parties, all parties to the exemption transaction may rely on the exemption.

§ 2570.50 Revocation or modification of exemptions.

(a) If, after an exemption takes effect, changes in circumstances, including changes in law or policy, occur which call into question the continuing validity of the Department's original conclusions concerning the exemption, the Department may take steps to revoke or modify the exemption.

(b) Before revoking or modifying an exemption, the Department will publish a notice of its proposed action in the FEDERAL REGISTER and provide interested persons with an opportunity to comment on the proposed revocation or modification. In addition, the Department will give the applicant at least 30 days notice in writing of the proposed revocation or modification and the reasons therefor and will provide the applicant with the opportunity to comment on the revocation or modification.

(c) Ordinarily the revocation or modification of an exemption will have prospective effect only.

§ 2570.51 Public inspection and copies.

(a) The administrative record of each exemption application will be open to public inspection and copying at the Public Disclosure Branch, PWBA, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210.

(b) Upon request, the staff of the Public Disclosure Branch will furnish photocopies of an administrative record, or any specified portion of that record, for a specified charge per page.

§ 2570.52 Effective date.

This regulation is effective with respect to all applications for exemptions filed with the Department under section 408(a) of ERISA, section 4975(c)(2) of the Code, or 5 U.S.C. 8477(c)(3) at any time on or after September 10, 1990. Applications for exemptions under section 408(a) of ERISA and/or section 4975 of the Code filed before September 10, 1990, are governed by ERISA Procedure 75–1. Applications for exemption under 5 U.S.C. 8477(c)(3) filed before September 10, 1990, but after December 29, 1988 are governed by part 2585 of chapter XXV of title 29 of the Code of Federal Regulations, (title 29 CFR part 2585 as revised July 1, 1990). Applications under 5 U.S.C. 8477(c)(3) filed before December 29, 1988 are governed by ERISA Procedure 75–1.

Subpart C—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(2)

SOURCE: 54 FR 26897, June 26, 1989, unless otherwise noted.

§ 2570.60 Scope of rules.

The rules of practice set forth in this subpart are applicable to ''502(c)(2) civil penalty proceedings'' (as defined in § 2570.61(n) of this subpart) under section 502(c)(2) of the Employee Retirement Income Security Act of 1974. The rules of procedure for administrative hearings published by the Department's Office of Law Judges at part 18 of this title will apply to matters arising under ERISA section 502(c)(2) except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.61 Definitions.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of the definitions in § 18.2 of this title:

(a) *Adjudicatory proceeding* means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;

(b) *Administrative law ludge* means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) *Answer* is defined for these proceedings as set forth in § 18.5(d)(1) of this title;

(d) *Commencement of proceeding* is the filing of an answer by the respondent;

(e) *Consent agreement* means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) *ERISA* means the Employee Retirement Income Security Act of 1974, as amended;

(g) *Final Order* means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(2) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of reasonable cause described in § 2560.502c–2(e) within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(h) *Hearing* means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) *Order* means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(2);

(j) *Party* includes a person or agency named or admitted as a party to a proceeding;

(k) *Person* includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(l) *Petition* means a written request, made by a a person or party, for some affirmative action;

(m) *Pleading* means the notice as defined in § 2560.502c–2(g), the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(n) *502(c)(2) civil penalty proceeding* means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(2) of ERISA;

(o) *Respondent* means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(2);

(p) *Secretary* means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Pension and Welfare Benefits), administrator, commissioner, appellate body, board, or other official; and

(q) *Solicitor* means the Solicitor of Labor or his or her delegate.

§ 2570.62 Service: Copies of documents and pleadings.

For 502(c)(2) penalty proceedings, this section shall apply in lieu of § 18.3 of this title.

(a) *General.* Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001-8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) *By parties.* All motions petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties or record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(2) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) *By the Office of Administrative Law Judges.* Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) *Form of pleadings.* (1) Every pleading shall contain information indicating the name of the Pension and Welfare Benefits Administration (PWBA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if

any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ × 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

[54 FR 26897, June 26, 1989, as amended at 56 FR 54708, Oct. 22, 1991]

§ 2570.63 Parties, how designated.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of § 18.10 of this title.

(a) The term ''party'' wherever used in these rules shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as ''respondent.'' The Department shall be designated as the ''complainant.''

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner's interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.64 Consequences of default.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of § 18.5 (a) and (b) of this title. Failure of the respondent to file an answer to the notice of determination described in § 2560.502c–2(g) within the 30-day period provided by § 2560.502c–2(h) shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(2). Such notice shall then become the final order of the Secretary.

§ 2570.65 Consent order or settlement.

For 502(c)(2) civil penalty proceedings, the following shall apply in lieu of § 18.9 of this title.

(a) *General.* At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) *Content.* Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and

(5) That the order and decision of the administrative law judge shall be final agency action.

(c) *Submission.* On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) *Disposition.* In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefore, the administrative law judge shall issue a decision incorporating such findings and agreement within thirty (30) days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) *Settlement without consent of all parties.* In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.66 Scope of discovery.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of § 18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish ''good cause'' for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which ''good cause'' has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party's representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representatives of a party concerning the proceeding.

§ 2570.67 Summary decision.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of § 18.41 of this title.

(a) *No genuine issue of material of fact.* (1) Where no issue of a material of fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§ 2570.69 through 2570.71 of this subpart, shall become a final order.

(2) A decision made under this paragraph shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) *Hearings on issues of fact.* Where a genuine question of material of fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.68 Decision of the administrative law judge.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of § 18.57 of this title.

(a) *Proposed findings of fact, conclusions, and order.* Within twenty (20) days of the filing of the transcript of the testimony of such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and briefs shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) *Decision of the administative law judge.* Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefor upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for 502(c)(2) civil penalty proceedings as set forth in this subpart, the penalty (if any) which may be included in the decision of the

administrative law judge shall be limited to the penalty expressly provided for in section 502(c)(2) of ERISA. It shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§ 2570.69 through 2570.71.

§ 2570.69 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.70 Scope of review.

The review of the Secretary shall not be *de novo* proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.71 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart D—Procedure for the Assessment of Civil Penalties Under ERISA Section 502(l)

SOURCE: 55 FR 25286, June 20, 1990, unless otherwise noted.

§ 2570.80 Scope of rules.

The rules of practice set forth in this subpart are applicable to ''502(l) civil penalty proceedings'' (as defined in § 2570.82 of this subpart) under section 502(l) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act). Refer to 29 CFR 2560.502–1 for the definition of the relevant terms of ERISA section 502(l).

§ 2570.81 In general.

Section 502(l) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) requires the Secretary of Labor to assess a civil penalty against a fiduciary who breaches a fiduciary responsibility under, or commits any other violation of, part 4 of title I of ERISA or any other person who knowingly participates in such breach or violation. The penalty under section 502(l) is equal to 20 percent of the ''applicable recovery amount'' paid pursuant to any settlement agreement with the Secretary or ordered by a court to be paid in a judicial proceeding instituted by the Secretary under section 502 (a)(2) or (a)(5). The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty if the Secretary determines in writing that:

(a) The fiduciary or other person acted reasonably and in good faith, or

(b) It is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan or any participant or beneficiary of such plan without severe financial hardship unless such waiver or reduction is granted.

The penalty imposed on a fiduciary or other person with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect

to such transaction under section 502(i) or section 4975 of the Internal Revenue Code of 1986 (the Code).

§ 2570.82 Definitions.

For purposes of this section:

(a) *502(l) civil penalty proceedings* means an adjudicatory proceeding relating to the assessment of a civil penalty provided in section 502(l) of ERISA;

(b) *Notice of assessment* means any document, however designated, issued by the Secretary which contains a specified assessment, in monetary terms, of a civil penalty under ERISA section 502(l). A ''notice of assessment'' will contain a brief factual description of the violation for which the assessment is being made, the identity of the person being assessed, and the amount of the assessment and the basis for assessing that particular person that particular penalty amount;

(c) *Person* includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(d) *Petition* means a written request, made by a person, for a waiver or reduction of the civil penalty described herein; and

(e) *Secretary* means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, the Assistant Secretary for Pension and Welfare Benefits, Area Directors for Pension and Welfare Benefits, or Deputy Area Directors for Pension and Welfare Benefits.

§ 2570.83 Assessment of civil penalty.

(a) Except as described in §§ 2570.85 and 2570.86 of this part, subsequent to the payment of the applicable recovery amount pursuant to either a settlement agreement or a court order, the Secretary shall serve on the person liable for making such payment a notice of assessment of civil penalty equal to 20 percent of the applicable recovery amount.

(b) Service of such notice shall be made either:

(1) By delivering a copy to the person being assessed; if the person is an individual, to the individual; if the person is a partnership, to any partner; if the person is a corporation, association, exchange, or other entity or organization, to any officer of such entity; if the person is an employee benefit plan, to a trustee of such plan; or to any attorney representing any such person;

(2) By leaving a copy at the principal office, place of business, or residence of such individual, partner, officer, trustee, or attorney; or

(3) By mailing a copy to the last known address of such individual, partner, officer, trustee, or attorney.

If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee.

§ 2570.84 Payment of civil penalty.

(a) The civil penalty must be paid within 60 days of service of the notice of assessment.

(b) At any time prior to the expiration of the payment period for the assessed penalty, any person who has committed, or knowingly participated in, a breach or violation, or has been alleged by the Secretary to have so committed or participated, may submit a written request for a conference with the Secretary to discuss the calculation of the assessed penalty. A person will be entitled under this section to one such conference per assessment. If such written request is submitted during the 60 day payment period described in subparagraph (a), such a request will not toll the running of that payment period.

(c) The notice of assessment will become a final order (within the meaning of 5 U.S.C. 704) on the first day following the 60 day payment period, subject to any tolling caused by a petition to waive or reduce described in § 2570.85.

§ 2570.85 Waiver or reduction of civil penalty.

(a) At any time prior to the expiration of the payment period for the assessed penalty, any person who has committed, or knowingly participated in, a breach or violation, or has been alleged by the Secretary to have so committed or participated, may petition the Secretary to waive or reduce the penalty under this section on the basis that:

(1) The person acted reasonably and in good faith in engaging in the breach or violation; or

(2) The person will not be able to restore all losses to the plan or participant or beneficiary of such plan without severe financial hardship unless such waiver or reduction is granted.

(b) All petitions for waiver or reduction shall be in writing and contain the following information:

(1) The name of the petitioner(s);

(2) A detailed description of the breach or violation which is the subject of the penalty;

(3) A detailed recitation of the facts which support one, or both, of the bases for waiver or reduction described in § 2570.85(a) of this part, accompanied by underlying documentation supporting such factual allegations;

(4) A declaration, signed and dated by the petitioner(s), in the following form:

Under penalty of perjury, I declare that, to the best of my knowledge and belief, the representations made in this petition are true and correct.

(c) If a petition for waiver or reduction is submitted during the 60 day payment period described in § 2570.84(a) of this part, the payment period for the penalty in question will be tolled pending Departmental consideration of the petition. During such consideration, the applicant is entitled to one conference with the Secretary, but the Secretary, in his or her sole discretion, may schedule or hold additional conferences with the petitioner concerning the factual allegations contained in the petition.

(d) Based solely on his or her discretion, the Secretary will determine whether to grant such a waiver or reduction. Pursuant to the procedure described in § 2570.83(b), the petitioner will be served with a written determination informing him or her of the Secretary's decision. Such written determination shall briefly state the grounds for the Secretary's decision, and shall be final and non-reviewable. In the case of a determination not to waive, the payment period for the penalty in question, if previously initiated, will resume as of the date of service of the Secretary's written determination.

§ 2570.86 Reduction of penalty by other penalty assessments.

The penalty assessed on a person pursuant to this section with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such person with respect to such transaction under ERISA section 502(i) and section 4975 of the Code. Prior to a reduction of penalty under this paragraph, the person being assessed must provide proof to the Department of the payment of the penalty or tax and the amount of that payment. Submissions of proof of other penalty or tax assessments will not toll the 60 day payment period, if previously initiated.

§ 2570.87 Revision of assessment.

If, based on the procedures described in § 2570.84, 2570.85, or 2570.86, the assessed penalty amount is revised, the person being assessed will receive a revised notice of assessment and will be obligated to pay the revised assessed penalty within the relevant 60 day payment period (as determined by the applicable procedure in § 2570.84, 2570.85, or 2570.86), and, if necessary, any excess penalty payment will be refunded as soon as administratively feasible. The revised notice of assessment will revoke any previously issued notice of assessment with regard to the transaction in question and will become a final order (within the meaning of 5 U.S.C. 704) the later of the first day following the 60 day payment period or the date of its service on the person being assessed, pursuant to the service procedures described in § 2570.83(b).

§ 2570.88 Effective date.

This section is effective June 20, 1990, and shall apply to assessments under section 502(l) made by the Secretary after June 20, 1990, based on any breach or violation occurring on or after December 19, 1989.

Subpart E—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(5)

SOURCE: 65 FR 7188, Feb. 11, 2000 unless otherwise noted.

§ 2570.90 Scope of rules.

The rules of practice set forth in this subpart are applicable to ''502(c)(5) civil penalty proceedings'' (as defined in § 2570.91(n) of this subpart) under section 502(c)(5) of the Employee Retirement Income Security Act of 1974 (Pub. L. 93–406, 88 Stat. 840–52, as amended by Pub. L. 104–191, 101 Stat. 1936). The rules of procedure for administrative hearings published by the Department's Office of Administrative Law Judges in Subpart A of Part 18 of this title will apply to matters arising under ERISA section 502(c)(5) except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.91 Definitions.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of the definitions in § 18.2 of this title.

(a) *Adjudicatory proceeding* means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;

(b) *Administrative law judge* means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) *Answer* means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to § 2560.502c–5(g);

(d) *Commencement of proceeding* is the filing of an answer by the respondent;

(e) *Consent agreement* means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) *ERISA* means the Employee Retirement Income Security Act of 1974, as amended;

(g) *Final Order* means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(5) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of reasonable cause described in § 2560.502c–5(e) within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(h) *Hearing* means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) *Order* means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(5);

(j) *Party* includes a person or agency named or admitted as a party to a proceeding;

(k) *Person* includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(l) *Petition* means a written request, made by a person or party, for some affirmative action;

(m) *Pleading* means the notice as defined in § 2560.502c–5(g), the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(n) 502(c)(5) civil penalty proceeding means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(5) of ERISA;

(o) *Respondent* means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(5);

(p) *Secretary* means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Pension and Welfare Benefits), administrator, commissioner, appellate body, board, or other official of the Department of Labor; and

(q) *Solicitor* means the Solicitor of Labor or his or her delegate.

§ 2570.92 Service: Copies of documents and pleadings.

For 502(c)(5) penalty proceedings, this section shall apply in lieu of § 18.3 of this title.

(a) *In general.* Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, N.W., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) *By parties.* All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(5) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) *By the Office of Administrative Law Judges.* Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) *Form of pleadings*—(1) Every pleading shall contain information indicating the name of the Pension and Welfare Benefits Administration (PWBA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½×11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.93 Parties, how designated.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of § 18.10 of this title.

(a) The term *party* wherever used in these rules shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as ''respondent.'' The Department shall be designated as the ''complainant.''

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner's interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the

requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.94 Consequences of default.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of § 18.5 (a) and (b) of this title. Failure of the respondents to file an answer to the notice of determination described in § 2560.502c–5(g) within the 30-day period provided by § 2560.502c–5(h) shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(5). Such notice shall then become a final order of the Secretary.

§ 2570.95 Consent order or settlement.

For 502(c)(5) civil penalty proceedings, the following shall apply in lieu of § 18.9 of this title.

(a) *In general.* At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such deferment and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) *Content.* Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and

(5) That the order and decision of the administrative law judge shall be final agency action.

(c) *Submission.* On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) *Disposition.* In the event that a settlement agreement containing consent findings and an order is submitted within the time allowed therefore, the administrative law judge shall issue a decision incorporating such findings and agreement within thirty (30) days of receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become a

final agency action within the meaning of 5 U.S.C. 704.

(e) *Settlement without consent of all parties.* In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether to sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.96 Scope of discovery.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of § 18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish ''good cause'' for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which ''good cause'' has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party's representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the proceeding.

§ 2570.97 Summary decision.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of § 18.41 of this title.

(a) *No genuine issue of material fact.* (1) Where no issue of material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to 2570.99 through 2570.101 of this subpart, shall become a final order.

(2) A decision made under this paragraph shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) *Hearings on issues of fact.* Where a genuine question of material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.98 Decision of the administrative law judge.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of § 18.57 of this title.

(a) *Proposed findings of fact, conclusions, and order.* Within twenty (20) days of the filing of the transcript of the testimony or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion, proposed findings of fact, conclusions of law, and an order together with a supporting brief expressing the reasons for such proposals. Such proposals and briefs shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) *Decision of the administrative law judge.* Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and an order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefor upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for 502(c)(5) civil penalty proceedings as set forth in this subpart, the penalty (if any) which may be included in the decision of the administrative law judge shall be limited to the penalty expressly provided for in section 502(c)(5) of ERISA. It shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become a final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§ 2570.99 through 2570.101.

§ 2570.99 Review by the Secretary

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.100 Scope of review.

The review of the Secretary shall not be a de novo proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.101 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart F—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(6)

SOURCE: 67 FR 786, Jan. 7, 2002, unless otherwise noted.

§ 2570.110 Scope of rules.

The rules of practice set forth in this subpart are applicable to ''502(c)(6) civil penalty proceedings'' (as defined in § 2570.111(n) of this subpart) under section 502(c)(6) of the Employee Retirement Income Security Act of 1974. The rules of procedure for administrative hearings published by the Department's Office of Law Judges at Part 18 of this title will apply to matters arising under ERISA section 502(c)(6) except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.111 Definitions.

For section 502(c)(6) civil penalty proceedings, this section shall apply in lieu of the definitions in § 18.2 of this title:

(a) *Adjudicatory proceeding* means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;

(b) *Administrative law judge* means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) *Answer* means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to § 2560.502c–6(g) of this chapter;

(d) *Commencement of proceeding* is the filing of an answer by the respondent;

(e) *Consent agreement* means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) *ERISA* means the Employee Retirement Income Security Act of 1974, as amended;

(g) *Final order* means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(6) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of matters reasonably beyond the control of the plan administrator described in § 2560.502c–6(e) of this chapter within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(h) *Hearing* means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) *Order* means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(6);

(j) *Party* includes a person or agency named or admitted as a party to a proceeding;

(k) *Person* includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(l) *Petition* means a written request, made by a person or party, for some affirmative action;

(m) *Pleading* means the notice as defined in § 2560.502c–6(g) of this chapter, the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(n) *502(c)(6) civil penalty proceeding* means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(6) of ERISA;

(o) *Respondent* means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(6);

(p) *Secretary* means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Pension and Welfare Benefits), administrator, commissioner, appellate body, board, or other official; and

(q) *Solicitor* means the Solicitor of Labor or his or her delegate.

§ 2570.112 Service: Copies of documents and pleadings.

For 502(c)(6) penalty proceedings, this section shall apply in lieu of § 18.3 of this title.

(a) *General.* Copies of all documents shall be served on all parties of record. All documents should clearly designate

the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) *By parties.* All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(6) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) *By the Office of Administrative Law Judges.* Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) *Form of pleadings.* (1) Every pleading shall contain information indicating the name of the Pension and Welfare Benefits Administration (PWBA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ × 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopied, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.113 Parties, how designated.

For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of § 18.10 of this title.

(a) The term ''party'' wherever used in this subpart shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as ''respondent''. The Department shall be designated as the ''complainant''.

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner's interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioner has the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or

deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner, as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.114 Consequences of default.

For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of § 18.5 (a) and (b) of this title. Failure of the respondent to file an answer to the notice of determination described in § 2560.502c–6(g) of this chapter within the 30-day period provided by § 2560.502c–6(h) of this chapter shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(6) of the Act. Such notice shall then become the final order of the Secretary.

§ 2570.115 Consent order or settlement.

For 502(c)(6) civil penalty proceedings, the following shall apply in lieu of § 18.9 of this title.

(a) *General.* At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such a deferral and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties, and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) *Content.* Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and

(5) That the order and decision of the administrative law judge shall be final agency action.

(c) *Submission.* On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) *Disposition.* In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within 30 days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) *Settlement without consent of all parties.* In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within 30 days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.116 Scope of discovery.

For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of § 18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish ''good cause'' for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which ''good cause'' has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party's representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representatives of a party concerning the proceeding.

§ 2570.117 Summary decision.

For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of § 18.41 of this title.

(a) *No genuine issue of material fact.* (1) Where no issue of a material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§ 2570.119 through 2570.121 of this subpart, shall become a final order.

(2) A decision made under this paragraph (a) shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) *Hearings on issues of fact.* Where a genuine question of a material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.118 Decision of the administrative law judge.

For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of § 18.57 of this title.

(a) *Proposed findings of fact, conclusions, and order.* Within twenty (20) days of the filing of the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and briefs shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) *Decision of the administrative law judge.* Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within 30 days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefor upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for 502(c)(6) civil penalty proceedings as set forth in this subpart, the penalty (if any) which may be included in the decision of the administrative law judge shall be limited to the penalty expressly provided for in section 502(c)(6) of ERISA. It shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§ 2570.119 through 2570.121.

§ 2570.119 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.120 Scope of review.

The review of the Secretary shall not be a *de novo* proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.121 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

PART 2575—ADJUSTMENT OF CIVIL PENALTIES UNDER ERISA TITLE I

Subpart A—Adjustment of Civil Penalties Under ERISA Title I

Sec.

2575.100 In general.
2575.209b–1 Adjusted civil penalty under section 209(b).

2575.502c–1 Adjusted civil penalty under section 502(c)(1).
2575.502c–2 Adjusted civil penalty under section 502(c)(2).
2575.502c–3 Adjusted civil penalty under section 502(c)(3).

Subpart B—D [Reserved]

AUTHORITY: 29 U.S.C. 1135; Secretary of Labor Order No. 1–87; sec. 4, Pub. L. 101–410; 104 Stat. 890 (28 U.S.C. 2461 note), as amended by sec. 31001(s)(1), Pub. L. 104–134, 110 Stat. 1321–373.

SOURCE: 64 FR 42246, Aug. 3, 1999, unless otherwise noted.

Subpart A—Adjustment of Civil Penalties Under ERISA Title I

SOURCE: 62 FR 40699, July 29, 1997, unless otherwise noted. Redesignated at 64 FR 42246, Aug. 3, 1999.

§ 2575.100 In general.

Section 3720E of the Debt Collection Improvement Act of 1996 (the Act, Pub. L. 104–134, 110 Stat. 1321–373) amended the Federal Civil Penalties Inflation Adjustment Act of 1990 (the 1990 Act, Pub. L. 101–410, 104 Stat. 890) to require generally that the head of each federal agency adjust the civil monetary penalties subject to its jurisdiction for inflation within 180 days after enactment of the Act and at lease once every four years thereafter.

§ 2575.209b–1 Adjusted civil penalty under section 209(b).

In accordance with the requirements of the 1990 Act, as amended, the amount of the civil monetary penalty established by section 209(b) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $10 for each employee to $11 for each employee. This adjusted penalty applies only to violations occurring after July 29, 1997.

§ 2575.502c–1 Adjusted civil penalty under section 502(c)(1).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $100 a day to $110 a day. This adjusted penalty applies only to violations occurring after July 29, 1997.

§ 2575.502c–2 Adjusted civil penalty under section 502(c)(2).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(2) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $1000 a day to $1100 a day. This adjusted penalty applies only to violations occurring after July 29, 1997.

§ 2575.502c–3 Adjusted civil penalty under section 502(c)(3).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(3) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $100 a day to $110 a day. This adjusted penalty applies only to violations occurring after July 29, 1997.

Subpart B—D [Reserved]

SUBCHAPTER H [RESERVED]
SUBCHAPTER I—TEMPORARY BONDING RULES UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2580—TEMPORARY BONDING RULES

Subpart A—Criteria for Determining Who Must Be Bonded

Sec.
2580.412–1 Statutory provisions.
2580.412–2 Plans exempt from the coverage of section 13.
2580.412–3 Plan administrators, officers and employees for purposes of section 13.
2580.412–4 ''Funds or other property'' of a plan.
2580.412–5 Determining when ''funds or other property'' belong to a plan.
2580.412–6 Determining when ''funds or other property'' are ''handled'' so as to require bonding.

Subpart B—Scope and Form of the Bond

2580.412–7 Statutory provision—scope of the bond.
2580.412–8 The nature of the duties or activities to which the bonding requirement relates.
2580.412–9 Meaning of fraud or dishonesty.
2580.412–10 Individual or schedule or blanket form of bonds.

Subpart C—Amount of the Bond

2580.412–11 Statutory provision.
2580.412–12 Relationship of determining the amount of the bond to ''handling''.
2580.412–13 The meaning of ''funds'' in determining the amount of the bond.
2580.412–14 Determining the amount of funds ''handled'' during the preceding reporting year.
2580.412–15 Procedures to be used for estimating the amount of funds to be ''handled'' during the current reporting year in those cases where there is no preceding reporting year.
2580.412–16 Amount of bond required in given types of bonds or where more than one plan is insured in the same bond.
2580.412–17 Bonds over $500,000.

Subpart D—General Bond Rules

2580.412–18 Naming of insureds.
2580.412–19 Term of the bond, discovery period, other bond clauses.
2580.412–20 Use of existing bonds, separate bonds and additional bonding.

Subpart E—Qualified Agents, Brokers and Surety Companies for the Placing of Bonds

2580.412–21 Corporate sureties holding grants of authority from the Secretary of the Treasury.
2580.412–22 Interests held in agents, brokers and surety companies.

Subpart F—Exemptions

BONDS PLACED WITH CERTAIN REINSURING COMPANIES

2580.412–23 Exemption.
2580.412–24 Conditions of exemption.

BONDS PLACED WITH UNDERWRITERS AT LLOYDS, LONDON

2580.412–25 Exemption.
2580.412–26 Conditions of exemption.

BANKING INSTITUTIONS SUBJECT TO FEDERAL REGULATION

2580.412–27 Exemption.
2580.412–28 Conditions of exemption.

SAVINGS AND LOAN ASSOCIATIONS SUBJECT TO FEDERAL REGULATION

2580.412–29 Exemption.
2580.412–30 Conditions of exemption.

INSURANCE CARRIERS, SERVICE AND OTHER SIMILAR ORGANIZATIONS

2580.412–31 Exemption.
2580.412–32 Conditions of exemption.

Subpart G—Prohibition Against Bonding by Parties Interested in the Plan

2580.412–33 Introductory statement.
2580.412–34 General.
2580.412–35 Disqualification of agents, brokers and sureties.
2580.412–36 Application of 13(c) to ''party in interest''.

AUTHORITY: Sec. 505, Pub. L. 93–406, 88 Stat. 894 (29 U.S.C. 1135); sec. 412(e), Pub. L. 93–406, 88 Stat. 889 (29 U.S.C. 1112).

SOURCE: 28 FR 14403, Dec. 27, 1963, unless otherwise noted. Redesignated at 50 FR 26706, June 28, 1985.

Subpart A—Criteria for Determining Who Must Be Bonded

§ 2580.412–1 Statutory provisions.

Section 13(a) of the Welfare and Pension Plans Disclosure Act of 1958, as amended, states, in part, that:

> Every administrator, officer and employee of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handles funds or other property of such plan shall be bonded as herein provided; except that, where such plan is one under which the only assets from which benefits are paid are the general assets of a union or of an employer, the administrator, officers and employees of such plan shall be exempt from the bonding requirements of this section.
>
> * * * Such bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of such administrator, officer, or employee, directly or through connivance with others.

§ 2580.412–2 Plans exempt from the coverage of section 13.

Only completely unfunded plans in which the plan benefits derive solely from the general assets of a union[1] or employer, and in which plan assets are not segregated in any way from the general assets of a union or employer and remain solely within the general assets until the time of distribution of benefits, shall be exempt from the bonding provisions. As such, the language ''where such plan is one under which the only assets from which benefits are paid are the general assets of a union or of an employer'' shall not be deemed to exempt a plan from the coverage of section 13 if the plan is one in which:

(a) Any benefits thereunder are provided or underwritten by an insurance carrier or service or other organization, or

(b) There is a trust or other separate entity to which contributions are made or out of which benefits are paid, or

(c) Contributions to the plan are made by the employees, either through withholding or otherwise, or from any source other than the employer or union involved, or

(d) There is a separately maintained bank account or separately maintained books and records for the plan or other evidence of the existence of a segregrated or separately maintained or administered fund out of which plan benefits are to be provided.

As a general rule, the presence of special ledger accounts or accounting entries for plan funds as an integral part of the general books and records of an employer or union shall not, in and of itself, be deemed sufficient evidence of segregation of plan funds to take a plan out of the exempt category, but shall be considered along with the other factors and criteria discussed above in determining whether the exemption applies. Again, it should be noted, however, that the fact that a plan is not exempt from the coverage of section 13 does not necessarily mean that its administrators, officers or employees are required to be bonded. As stated previously, this will depend in each case on whether or not they ''handle'' funds or other property of the plan within the meaning of section 13 and under the standards set forth in § 2580.412–6.

§ 2580.412–3 Plan administrators, officers and employees for purposes of section 13.

(a) *Administrator*. (1) For purposes of the bonding provisions, the term ''administrator'' is defined in the same manner as under section 5 of the Act and refers to:

(i) The person or persons designated by the terms of the plan or the collective bargaining agreement with responsibility for the ultimate control, disposition, or management of the money received or contributed; or

(ii) In the absence of such designation, the person or persons actually responsible for the control, disposition, or management of the money received or contributed, irrespective of whether

[1] For purposes of the exemption discussed in § 2580.412–2, the term ''union'' shall include ''* * * any organization of any kind or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose in whole or in part, of dealing with employers concerning an employee welfare or pension benefit plan, or other matters incidental to employement relationships * * *'' (29 U.S.C. 302(a)(3)).

such control, disposition, or management is exercised directly or through an agent or trustee designated by such person or persons.

(2) Where by virtue of this definition, or regulations, interpretations or opinions issued with respect thereto, the term embodies natural persons such as members of the board of trustees of a trust, the bonding requirements shall apply to such persons.

(3) However, when by virtue of this definition or regulations, interpretations, or opinions issued with respect thereto, the administrator in a given case in an entity such as a partnership, corporation, mutual company, joint stock company, trust, unincorporated organization, union or employees' beneficiary association, the term shall be deemed to apply, in meeting the bonding requirements, only to those natural persons who:

(i) Are vested under the authority of the entity-administrator with the responsibility for carrying out functions constituting control, disposition or management of the money received or contributed within the definition of administrator, or who, acting on behalf of or under the actual or apparent authority of the entity-administrator, actually perform such functions, and who

(ii) ''Handle'' funds or other property of the plan within the meaning of these regulations.

(b) *Officers*. For purposes of the bonding provisions, the term ''officer'' shall include any person designated by the terms of a plan or collective bargaining agreement as an officer, any person performing or authorized to perform executive functions of the plan or any member of a board of trustees or similar governing body of a plan. The term shall include such persons regardless of whether they are representatives of or selected by an employer, employees or an employee organization. In its most frequent application the term will emcompass those natural persons appointed or elected as officers of the plan or as members of boards or committees performing executive or supervisory functions for the plan, but who do not fall within the definition of administrator.

(c) *Employees*. For purposes of the bonding provisions the term ''employee'' shall, to the extent a person performs functions not falling within the definition of officer or administrator, include any employee who performs work for or directly related to a covered plan, regardless of whether technically he is employed, directly or indirectly, by or for a plan, a plan administrator, a trust, or by an employee organization or employer within the meaning of section 3(3) or 3(4) of the Act.

(d) *Other persons covered*. For purposes of the bonding provisions, the terms ''administrator, officer, or employee'' shall include any persons performing functions for the plan normally performed by administrators, officers, or employees of a plan. As such, the terms shall include persons indirectly employed, or otherwise delegated, to perform such work for the plan, such as pension consultants and planners, and attorneys who perform ''handling'' functions within the meaning of § 2580.412–6. On the other hand, the terms would not include those brokers or independent contractors who have contracted for the performance of functions which are not ordinarily carried out by the administrators, officers, or employees of a plan, such as securities, brokers who purchase and sell securities or armored motor vehicle companies.

[28 FR 14403, Dec. 27, 1963, as amended at 34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

§ 2580.412–4 "Funds or other property" of a plan.

The affirmative requirement for bonding persons falling within the definition of administrator, officer or employee is applicable only if they handle ''funds or other property'' of the plan concerned. The term ''funds or other property'' is intended to encompass all property which is used or may be used as a source for the payment of benefits to plan participants. It does not include permanent assets used in the operation of the plan such as land and buildings, furniture and fixtures or office and delivery equipment used in the operation of the plan. It does include all items in the nature of quick assets,

such as cash, checks and other negotiable instruments, government obligations and marketable securities. It also includes all other property or items convertible into cash or having a cash value and held or acquired for the ultimate purpose of distribution to plan participants or beneficiaries. In the case of a plan which has investments, this would include all the investments of the plan even though not in the nature of quick assets, such as land and buildings, mortgages, and securities in closely held corporations. However, in a given case, the question of whether a person was ''handling'' such ''funds or other property'' so as to require bonding would depend on whether his relationship to this property was such that there was a risk that he, alone or in connivance with others, could cause a loss of such ''funds or other property'' through fraud or dishonesty.

§ 2580.412–5 Determining when "funds or other property" belong to a plan.

With respect to any contribution to a plan from any source, including employers, employees or employee organizations, the point at which any given item or amount becomes ''funds or other property'' of a plan for purposes of the bonding provisions shall be determined as described in this section.

(a) Where the plan administrator is a board of trustees, person or body other than the employer or employee organization establishing the plan, a contribution to the plan from any source shall become ''funds or other property'' of the plan at the time it is received by the plan administrator. Employee contributions collected by an employer and later turned over to the plan administrator would not become ''funds or other property'' of the plan until receipt by the plan administrator.

(b) Where the employer or employee organization establishing the plan is itself the plan administrator:

(1) Contributions from employees or other persons who are plan participants would normally become ''funds or other property'' of the plan at the time they are received by the employer or employee organization, except however that contributions made by withholding from employees' salaries shall not be considered ''funds or other property'' of the plan for purposes of the bonding provisions so long as they are retained in and not segregated in any way from the general assets of the withholding employer or employee organization.

(2) Contributions made to a plan by such employer or employee organization and contributions made by withholdings from employees' salaries would normally become ''funds or other property'' of the plan if and when they are taken out of the general assets of the employer or employee organization and placed in a special bank account or investment account; or identified on a separate set of books and records; or paid over to a corporate trustee or used to purchase benefits from an insurance carrier or service or other organization; or otherwise segregated, paid out or used for plan purposes, whichever shall occur first. Thus, if a plan is operated by a corporate trustee and no segregation from general assets is made of monies to be turned over to the corporate trustee prior to the actual transmittal of such monies, the contribution represented in the transmission becomes ''funds or other property'' of the plan at the time of receipt by the corporate trustee. On the other hand, if a special fund is first established from which monies are paid over to the corporate trustee, a given item would become ''funds or other property'' of the plan at the time it is placed in the special fund. Similarly, if plan benefits are provided through the medium of an insurance carrier or service or other organization and no segregation from general assets of monies used to purchase such benefits is made prior to turning such monies over to the organization contracting to provide benefits, plan funds or other property come into being at the time of receipt of payment for such benefits by the insurance carrier or service or other organization. In such a case, the ''funds or other property'' of the plan would be represented by the insurance contract or other obligations to pay benefits and would not be normally subject to ''handling''. Bonding would not be required for any person with respect to the purchase of such benefits directly from general assets nor with respect to

the bare existence of the contract obligation to pay benefits. However, if the particular, arrangement were such that monies derived from, or by virtue of, the contract did subsequently flow back to the plan, bonding may be required if such monies returning to the plan are handled by plan administrators, officers or employees. (Further discussion on bonding of insured plans is contained in § 2580.412–6(b)(7)).

§ 2580.412–6 Determining when "funds or other property" are "handled" so as to require bonding.

(a) *General scope of term.* (1) A plan administrator, officer, or employee shall be deemed to be ''handling'' funds or other property of a plan, so as to require bonding under section 13, whenever his duties or activities with respect to given funds or other property are such that there is a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of such person, acting either alone or in collusion with others. While ordinarily, those plan administrators, officers and employees who ''handle'' within the meaning of section 13 will be those persons with duties related to the receipt, safekeeping and disbursement of funds, the scope of the term ''handles'' and the prohibitions of paragraph (b) of section 13 shall be deemed to encompass any relationship of an administrator, officer or employee with respect to funds or other property which can give rise to a risk of loss through fraud or dishonesty. This shall include relationships such as those which involve access to funds or other property or decisionmaking powers with respect to funds or property which can give rise to such risk of loss.

(2) Section 13 contains no exemptions based on the amount or value of funds or other property ''handled'', nor is the determination of the existence of risk of loss based on the amount involved. However, regardless of the amount involved, a given duty or relationship to funds or other property shall not be considered ''handling'', and bonding is not required, where it occurs under conditions and circumstances in which the risk that a loss will occur through fraud or dishonesty is negligible. This may be the case where the risk of mishandling is precluded by the nature of the funds or other property (e.g., checks, securities or title papers which can not be negotiated by the persons performing duties with respect to them). It may also be the case where significant risk of mishandling in the performance of duties of an essentially clerical character is precluded by fiscal controls.

(b) *General criteria for determining ''handling''.* Subject to the application of the basic standard of risk of loss to each situation, general criteria for determining whether there is ''handling'' so as to require bonding are:

(1) *Physical contact.* Physical contact with cash, checks or similar property generally constitutes ''handling''. However, persons who from time to time perform counting, packaging, tabulating, messenger or similar duties of an essentially clerical character involving physical contact with funds or other property would not be ''handling'' when they perform these duties under conditions and circumstances where risk of loss is negligible because of factors such as close supervision and control or the nature of the property.

(2) *Power to exercise physical contact or control.* Whether or not physical contact actually takes place, the power to secure physical possession of cash, checks or similar property through factors such as access to a safe deposit box or similar depository, access to cash or negotiable assets, powers of custody or safekeeping, power to withdraw funds from a bank or other account generally constitutes ''handling'', regardless of whether the person in question has specific duties in these matters and regardless of whether the power or access is authorized.

(3) *Power to transfer to oneself or a third party or to negotiate for value.* With respect to property such as mortgages, title to land and buildings, or securities, while physical contact or the possibility of physical contact may not, of itself, give rise to risk of loss so as to constitute ''handling'', a person shall be regarded as ''handling'' such items where he, through actual or apparent authority, can cause those items to be transferred to himself or to a third party or to be negotiated for value.

(4) *Disbursement.* Persons who actually disburse funds or other property, such as officers or trustees authorized to sign checks or other negotiable instruments, or persons who make cash disbursements, shall be considered to be ''handling'' such funds or property. Whether other persons who may influence, authorize or direct disbursements or the signing or endorsing of checks or similar instruments will be considered to be ''handling'' funds or other property shall be determined by reference to the particular duties or responsibilities of such persons as applied to the basic criteria of risk of loss.

(5) *Signing or endorsing checks or other negotiable instruments.* In connection with disbursements or otherwise, any persons with the power to sign or endorse checks or similar instruments or otherwise render them transferable, whether individually or as co-signers with one or more persons, shall each be considered to be ''handling'' such funds or other property.

(6) *Supervisory or decision making responsibility.* To the extent a person's supervisory or decision making responsibility involves factors in relationship to funds discussed in paragraph (b)(1), (2), (3), (4), or (5) of this section, such persons shall be considered to be ''handling'' in the same manner as any person to whom the criteria of those paragraphs apply. To the extent that only general responsibility for the conduct of the business affairs of the plan is involved, including such functions as approval of contracts, authorization of disbursements, auditing of accounts, investment decisions, determination of benefit claims and similar responsibilities, such persons shall be considered to be ''handling'' whenever the facts of the particular case raise the possibility that funds or other property of the plan are likely to be lost in the event of their fraud or dishonesty. The mere fact of general supervision would not necessarily, in and of itself, mean that such persons are ''handling.'' Factors to be accorded weight are the system of fiscal controls, the closeness and continuity of supervision, who is in fact charged with, or actually exercising final responsibility for determining whether specific disbursements, investments, contracts, or benefit claims are bona fide, regular and made in accordance with the applicable trust instrument or other plan documents.

(i) For example, persons having supervisory or decisionmaking responsibility would be ''handling'' to the extent they:

(*a*) Act in the capacity of plan ''administrator'' and have ultimate responsibility for the plan within the meaning of the definition of ''administrator'' (except to the extent that it can be shown that such persons could not, in fact, cause a loss to the plan to occur through fraud or dishonesty);

(*b*) Exercise close supervision over corporate trustees or other parties charged with dealing with plan funds or other property; exercise such close control over investment policy that they, in effect, determine all specific investments;

(*c*) Conduct, in effect, a continuing daily audit of the persons who ''handle'' funds;

(*d*) Regularly review and have veto power over the actions of a disbursing officer whose duties are essentially ministerial.

(ii) On the other hand, persons having supervisory or decisionmaking responsibility would not be ''handling'' to the extent:

(*a*) They merely conduct a periodic or sporadic audit of the persons who ''handle'' funds;

(*b*) Their duties with respect to investment policy are essentially advisory;

(*c*) They make a broad general allocation of funds or general authorization of disbursements intended to permit expenditures by a disbursing officer who has final responsibility for determining the propriety of any specific expenditure and making the actual disbursement;

(*d*) A bank or corporate trustee has all the day to day functions of administering the plan;

(*e*) They are in the nature of a Board of Directors of a corporation or similar authority acting for the corporation rather than for the plan and do not perform specific functions with respect to the operations of the plan.

(7) *Insured plan arrangements.* In many cases, plan contributions made

by employers or employee organizations or by withholding from employee's salaries are not segregated from the general assets of the employer or employee organization until payment for purchase of benefits from an insurance carrier or service or other organization. No bonding is required with respect to the payment of premiums or other payments made to purchase such benefits directly from general assests, nor with respect to the bare existence of the contract obligation to pay benefits. Such arrangements would not normally be subject to bonding except to the extent that monies returned by way of benefit payments, cash surrender, dividends, credits or otherwise, and which by the terms of the plan belonged to the plan (rather than to the employer, employee organization, insurance carrier or service or other organization) were subject to ''handling'' by plan administrators, officers or employees.

Subpart B—Scope and Form of the Bond

§ 2580.412–7 Statutory provision—scope of the bond.

The statute requires that the bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of a plan administrator, officer, or employee, directly or through connivance with others.

§ 2580.412–8 The nature of the duties or activities to which the bonding requirement relates.

The bond required under section 13 is limited to protection for those duties and activities from which loss can arise through fraud or dishonesty. It is not required to provide the same scope of coverage that is required in faithful discharge of duties bonds under the Labor-Management Reporting and Disclosure Act of 1959 or in the faithful performance bonds of public officials.

§ 2580.412–9 Meaning of fraud or dishonesty.

The term ''fraud or dishonesty'' shall be deemed to encompass all those risks of loss that might arise through dishonest or fraudulent acts in handling of funds as delineated in § 2580.412–6. As such, the bond must provide recovery for loss occasioned by such acts even though no personal gain accrues to the person committing the act and the act is not subject to punishment as a crime or misdemeanor, provided that within the law of the state in which the act is committed, a court would afford recovery under a bond providing protection against fraud or dishonesty. As usually applied under state laws, the term ''fraud or dishonesty'' encompasses such matters as larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, wrongful conversion, willful misapplication or any other fraudulent or dishonest acts. For the purposes of section 13, other fraudulent or dishonest acts shall also be deemed to include acts where losses result through any act or arrangement prohibited by title 18, section 1954 of the U.S. Code.

§ 2580.412–10 Individual or schedule or blanket form of bonds.

Section 13 provides that ''any bond shall be in a form or of a type approved by the Secretary, including individual bonds or schedule or blanket forms of bonds which cover a group or class''. Any form of bond which may be described as individual, schedule or blanket in form or any combination of such forms of bonds shall be acceptable to meet the requirements of section 13, provided that in each case, the form of the bond, in its particular clauses and application, is not inconsistent with meeting the substantive requirements of the statute for the persons and plan involved and with meeting the specific requirements of the regulations in this part. Basic types of bonds in general usage are:

(a) *Individual bond.* Covers a named individual in a stated penalty.

(b) *Name schedule bond.* Covers a number of named individuals in the respective amounts set opposite their names.

(c) *Position schedule bond.* Covers each of the occupants of positions listed in the schedule in the respective amounts set opposite such positions.

(d) *Blanket bonds.* Cover all the insured's officers and employees with no schedule or list of those covered being necessary and with all new officers and

employees bonded automatically, in a blanket penalty which takes two forms—an aggregate penalty bond and a multiple penalty bond which are described below:

(1) The aggregate penalty blanket bond such as the Commercial Blanket Bond; the amount of the bond is available for dishonesty losses caused by persons covered thereunder or losses in which such person is concerned or implicated. Payment of loss on account of any such person does not reduce the amount of coverage available for losses other than those caused by such person or in which he was concerned or implicated.

(2) The multiple penalty bond such as the Blanket Position Bond giving separate coverage on each person for a uniform amount—the net effect being the same as though a separate bond were issued on each person covered thereunder and all of such bonds being for a uniform amount.

NOTE: For the purpose of section 13, blanket bonds which are either aggregate penalty or multiple penalty in form shall be permissible if they otherwise meet the requirements of the Act and the regulations in this part.

Bonding, to the extent required, of persons indirectly employed, or otherwise delegated, to perform functions for the plan which are normally performed by ''administrators, officers, or employees'' as described in § 2580.412–3(d) may be accomplished either by including them under individual or schedule bonds or other forms of bonds meeting the requirements of the Act, or naming them in what is known under general trade usage as an ''Agents Rider'' attached to a Blanket Bond.

Subpart C—Amount of the Bond

§ 2580.412–11 Statutory provision.

Section 13 requires that the amount of the bond be fixed at the beginning of each calendar, policy or other fiscal year, as the case may be, which constitutes the reporting year of the plan for purposes of the reporting provisions of the Act. The amount of the bond shall be not less than 10 per centum of the amount of funds handled, except that any such bond shall be in at least the amount of $1,000 and no such bond shall be required in an amount in excess of $500,000: *Provided,* That the Secretary, after due notice and opportunity for hearing to all interested parties, and after consideration of the record, may prescribe an amount in excess of $500,000, which in no event shall exceed 10 per centum of the funds handled. For purposes of fixing the amount of such bond, the amount of funds handled shall be determined by the funds handled by the person, group, or class to be covered by such bond and by their predecessor or predecessors, if any, during the preceding reporting year, or if the plan has no preceding reporting year, the amount of funds to be handled during the current reporting year by such person, group, or class, estimated as provided in the regulations in this part. With respect to persons required to be bonded, section 13 shall be deemed to require the bond to insure from the first dollar of loss up to the requisite bond amount and not to permit the use of deductible or similar features whereby a portion of the risk within such requisite bond amount is assumed by the insured. Any request for variance from these requirements shall be made pursuant to the provisions of section 13(e) of the Act.

§ 2580.412–12 Relationship of determining the amount of the bond to "handling".

A determination of whether persons falling within the definition of administrator, officer or employee are required to be bonded depends on whether they ''handle'' funds or other property. Determining the amount of the bond is an aspect of the same process in that it requires a determination of what funds or other property are being handled or what amounts of funds or other property are subject to risk of loss with respect to the duties or powers of an administrator, officer or employee of a covered plan. Once this calculation is made, the required amount for which that person must be covered by a bond, either by himself or as a part of a group or class being bonded under a blanket or schedule bond, is not less than 10 percent of the amount ''handled'' or $1,000, whichever is the greater amount, except that no such bond shall be required in an amount

greater than $500,000 by virtue of these regulations. (See § 2580.412–17.)

§ 2580.412–13 The meaning of "funds" in determining the amount of the bond.

The amount of the bond depends on the amount of ''funds'' ''handled'', and shall be sufficient to provide bonding protection against risk of loss through fraud or dishonesty for all plan funds, including other property similar to funds or in the nature of funds. As such, the term ''funds'' shall be deemed to include and be equivalent to ''funds and other property'' of the plan as described in § 2580.412–4. With respect to any item of ''funds or other property'' which does not have a cash or readily ascertainable market value, the value of such property may be estimated on such basis as will reasonably reflect the loss the plan might suffer if it were mishandled.

§ 2580.412–14 Determining the amount of funds "handled" during the preceding reporting year.

(a) The amount of funds ''handled'' by each person falling within the definition of administrator, officer, or employee (or his predecessors) during the preceding reporting year shall be the total of funds subject to risk of loss, within the meaning of the definition of ''handling'' (see § 2580.412–6), through acts of fraud or dishonesty, directly or in connivance with others, by such person or his predecessors during the preceding reporting year. The relationship of the determination of the amount of funds ''handled'' to the determination of who is ''handling'' can best be illustrated by a situation that commonly arises with respect to executive personnel of a plan, where a bank or corporate trustee has the responsibility for the receipt, safekeeping, physical handling and investment of a plan's assets and the basic function of the executive personnel is to authorize payments to beneficiaries and payments for services to the corporate trustee, the actuary and the employees of the plan itself. Normally, in any given year, only a small portion of the plan's total assets is disbursed, and the question arises as to whether an administrator or executive personnel are ''handling'' only the amounts actually disbursed each year or whether they are ''handling'' the total amounts of the assets. The answer to this question depends on the same basic criterion that governs all questions of ''handling'', namely, the possibility of loss. If the authorized duties of the persons in question are strictly limited to disbursements of benefits and payments for services, and the fiscal controls and practical realities of the situation are such that these persons cannot gain access to funds which they are not legitimately allowed to disburse, the amount on which the bond is based may be limited to the amount actually disbursed in the reporting year. This would depend, in part, on the extent to which the bank or corporate trustee which has physical possession of the funds also has final responsibility for questioning and limiting disbursements from the plan, and on whether this responsibility is embodied in the original plan instruments. On the other hand, where insufficient fiscal controls exist so that the persons involved have free access to, or can obtain control of, the total amount of the fund, the bond shall reflect this fact and the amount ''handled'' shall be based on the total amount of the fund. This would generally occur with respect to persons such as the ''administrator'', regardless of what functions are performed by a bank or corporate trustee, since the ''administrator'' by definition retains ultimate power to revoke any arrangement with a bank or corporate trustee. In such case, the ''administrator'' would have the power to commit the total amount of funds involved to his control, unless the plan itself or other specific agreement (1) prevents the ''administrator'' from so doing or (2) requires that revocation cannot be had unless a new agreement providing for similar controls and limitations on the ''handling'' of funds is simultaneously entered into.

(b) Where the circumstances of ''handling'' are such that the total amount of a given account or fund is subject to ''handling'', the amount ''handled'' shall include the total of all such funds on hand at the beginning of the reporting year, plus any items received during the year for any reason,

such as contributions or income, or items received as a result of sales, investments, reinvestment, interest or otherwise. It would not, however, be necessary to count the same item twice in arriving at the total funds ''handled'' by a given person during a reporting year. For example, a given person may have various duties or powers involving receipt, safekeeping or disbursement of funds which would place him in contact with the same funds at several times during the same year. Different duties, however, would not make it necessary to count the same item twice in arriving at the total ''handled'' by him. Similarly, where a person has several different positions with respect to a plan, it would not be necessary to count the same funds each time that they are ''handled'' by him in these different positions, so long as the amount of the bond is sufficient to meet the 10 percent requirement with respect to the total funds ''handled'' by him subject to risk or loss through fraud or dishonesty, whether acting alone or in collusion with others. In general, once an item properly within the category of ''funds,'' has been counted as ''handled'' by a given person, it need not be counted again even though it should subsequently be ''handled'' by the same person during the same year.

§ 2580.412–15 Procedures to be used for estimating the amount of funds to be "handled" during the current reporting year in those cases where there is no preceding reporting year.

If for any reason a plan does not have a complete preceding reporting year, the amount ''handled'' by persons required to be covered by a bond shall be estimated at the beginning of the calendar, policy or other fiscal year, as the case may be, which would constitute either the operating year or the reporting year of the plan, whichever shall occur first, as follows:

(a) In the case of a plan having a previous experience year, even though it has no preceding reporting year, the estimate of the amount to be ''handled'' for any person required to be covered shall be based on the experience in the previous year by applying the same standards and criteria as in a plan which has a preceding reporting year. Similarly, where a plan is recently established, but has had, at the time a bond is obtained, sufficient experience to reasonably estimate a complete year's experience for persons required to be bonded, the amount of funds to be ''handled'' shall be projected to the complete year on the basis of the period in which the plan has had experience, unless, to the knowledge of the plan administrator, the given period of experience is so seasonal or unrepresentative of the complete year's experience as not to provide a reasonable basis for projecting the estimate for the complete year.

(b) Where a plan does not have any prior experience sufficient to allow it to estimate the amount ''handled'' in the manner outlined in paragraph (a) of this section, the amount to be ''handled'' by the administrators, officers and employees of the plan during the current reporting year shall be that amount initially required to fund or set up the plan, plus the amount of contributions required to be made under the plan formula from any source during the current reporting year. In most cases, the amount of contributions will be calculated by multiplying the total yearly contribution per participant (required by the plan formula from either employers, employees, employer organizations or any other source) by the number of participants in the plan at the beginning of such reporting year. In cases where the per capita contribution cannot readily be determined, such as in the case of certain insured plans covered by the Act, the amount of contributions shall be estimated on the amount of insurance premiums which are actuarially estimated as necessary to support the plan, or on such other actuarially estimated basis as may be applicable. In the case of a newly formed profit-sharing plan covered by the Act, if the employer establishing the plan has a previous year of experience, the amount of contributions required by the plan formula shall be estimated on the basis of the profits of the previous year. The amount of the bond shall then be fixed at 10 percent of this calculation, but not more than $500,000. A bond for such amount shall be obtained in any form

the plan desires on all persons who are administrators, officers, or employees of the plan and who ''handle'' funds or other property of the plan.

§ 2580.412–16 Amount of bond required in given types of bonds or where more than one plan is insured in the same bond.

(a) As indicated in § 2580.412–10, the Act permits the use of blanket, schedule and individual forms of bonds so long as the amount of the bond penalty is sufficient to meet the requirements of the Act for any person who is an administrator, officer or employee of a plan handling funds or other property of the plan. Such person must be bonded for 10 percent of the amount he handles, and the amount of the bond must be sufficient to indemnify the plan for any losses in which such person is involved up to that amount.

(b) When individual or schedule bonds are written, the bond amount for each person must represent not less than 10 percent of the funds ''handled'' by the named individual or by the person in the position. When a blanket bond is written, the amount of the bond shall be at least 10 percent of the highest amount handled by any administrator, officer or employee to be covered under the bond. It should also be noted that if an individual or group or class covered under a blanket bond ''handle'' a large amount of funds or other property, while the remaining bondable persons ''handle'' only a smaller amount, it is permissible to obtain a blanket bond in an amount sufficient to meet the 10 percent requirements for all except the individual, group or class ''handling'' the larger amounts, with respect to whom excess indemnity shall be secured in an amount sufficient to meet the 10 percent requirement.

(c) The Act does not prohibit more than one plan from being named as insured under the same bond. However, any such bond must allow for recovery by each plan in an amount at least equal to that which would be required if bonded separately. This requirement has application where a person or persons sought to be bonded pursuant to the requirements of section 13 have ''handling'' functions in more than one plan covered under the bond. Where such is the case, the amount of the bond must be sufficient to cover any such persons having functions in more than one plan for at least 10 percent of the total amount ''handled'' by them in all the plans covered under the bond. For example, X is the administrator of two welfare plans run by the same employer and he ''handled'' $100,000 in the preceding reporting year for Plan A and $500,000 in the preceding reporting year for Plan B. If both plans are covered under the same bond, the amount of the bond with respect to X shall be at least $60,000 or ten percent of the total ''handled'' by X for both plans covered under the bond in which X has powers and duties of ''handling'' since Plan B is required to carry bond in at least the amount of $50,000 and Plan A, $10,000.

(d) Additionally, in order to meet the requirement that each plan be protected, it shall be necessary that arrangement be made either by the terms of the bond or rider to the bond or by separate agreement among the parties concerned, that payment of a loss sustained by one of such insureds shall not work to the detriment of any other plan covered under the bond with respect to the amount for which that plan is required to be covered. For example, if Plan A suffered a loss of $30,000 as described above and such loss was recompensed in its entirety by the surety company, it would receive $20,000 more than the $10,000 protection required under section 13, and only $30,000 would be available for recovery with respect to further losses caused by X. In a subsequently discovered defalcation of $40,000 by X from Plan B, it would be necessary that the bond, rider, or separate agreement provide that such amount of recovery paid to Plan A in excess of the $10,000 for which it is required to be covered, be made available by such insured to, or held for the use of, Plan B in such amount as Plan B would receive if bonded separately. Thus, in the instant case, Plan B would be able to recover the full $40,000 of its loss. Where the funds or other property of several plans are commingled (if permitted by law) with each other or with other funds, such arrangement shall allow recovery to be attributed proportionately to the

amount for which each plan is required to be protected. Thus, in the instant case, if funds or other property were commingled, and X caused a loss of these funds through fraud or dishonesty, one-sixth of the loss would be attributable to Plan A and five-sixths of the loss attributable to Plan B.

(e) The maximum amount of any bond with respect to any person in any one plan in $500,000, but bonds covering more than one plan may be required to be over $500,000 in order to meet the requirements of the Act, since persons covered by such a bond may have ''handling'' functions in more than one plan. The $500,000 limitations for such persons applies only with respect to each separate plan in which they have such functions. The minimum bond coverage for any administrator, officer, or employee ''handling'' funds or other property of a plan is $1,000 as respects each plan in which he has ''handling'' functions.

§ 2580.412–17 Bonds over $500,000.

The Labor-Management Services Administrator, after due notice and opportunity for hearing to all interested parties, and after consideration of the record, may prescribe an amount in excess of $500,000, which in no event shall exceed 10 per centum of the funds ''handled.'' Any requirement for bonding in excess of $500,000 shall be according to such other regulations as may be prescribed.

Subpart D—General Bond Rules

§ 2580.412–18 Naming of insureds.

Since section 13 is intended to protect funds or other property of all plans involved, bonds under this section shall allow for enforcement or recovery by those persons usually authorized to act for such plans in such matters. In most cases, the naming of the plan or plans as insured will provide for such recovery. Where it is not clear that such recovery will be provided, however, a rider shall be attached to the bond or separate agreement made among the parties concerned to make certain that any reimbursement collected under the bond will be for the benefit and use of the plan suffering a loss. Such rider or agreement shall always be required as respects any bond (a) where the employer or employee organization is first named joint insured with one or more plans, or (b) two or more plans are named joint insureds under a single bond with the first named acting for all insureds for the purpose of orderly servicing of the bond.

§ 2580.412–19 Term of the bond, discovery period, other bond clauses.

(a) *Term of the bond.* The amount of any required bond must in each instance be based on the amount of funds ''handled'' and must be fixed or estimated at the beginning of the plan's reporting year, that is, as soon after the date when such year begins as the necessary information from the preceding reporting year can practicably be ascertained. This does not mean, however, that a new bond must be obtained each year. There is nothing in the Act that prohibits a bond for a term longer than one year, with whatever advantages such a bond might offer by way of a lower premium. However, at the beginning of each reporting year the bond shall be in at least the requisite amount. If, for any reason, the bond is below the required level at that time, the existing bond shall either be increased to the proper amount, or a supplemental bond shall be obtained.

(b) *Discovery period.* A discovery period of no less than one year after the termination or cancellation of the bond is required. Any standard form written on a ''discovery'' basis, i.e., providing that a loss must be discovered within the bond period as a prerequisite to recovery of such loss, however, will not be required to have a discovery period if it contains a provision giving the insured the right to purchase a discovery period of one year in the event of termination or cancellation and the insured has already given the surety notice that it desires such discovery period.

(c) *Other bond clauses.* A bond shall not be adequate to meet the requirements of section 13, if, with respect to bonding coverage required under section 13, it contains a clause, or is otherwise, in contravention of the law of the State in which it is executed.

§ 2580.412–20 Use of existing bonds, separate bonds and additional bonding.

(a) *Additional bonding.* Section 13 neither prevents additional bonding beyond that required by its terms, nor prescribes the form in which additional coverage may be taken. Thus, so long as a particular bond meets the requirements of the regulations in this part as to the persons required to be bonded and provides coverage for such persons in at least the minimum required amount, additional coverage as to persons or amount may be taken in any form, either on the same or separate bond.

(b) *Use of existing bonds.* Insofar as a bond currently in use is adequate to meet the requirements of the Act and the regulations in this part or may be made adequate to meet these requirements through rider, modification or separate agreement between the parties, no further bonding is required.

(c) *Use of separate bonds.* The choice of whether persons required to be bonded should be bonded separately or under the same bond, whether given plans should be bonded separately or under the same bond, whether existing bonds should be used or separate bonds for Welfare and Pension Plans Disclosure Act bonding should be obtained, or whether the bond is underwritten by a single surety company or more than one surety company, either separately or on a cosurety basis, is left to the judgment of the parties concerned, so long as the bonding program adopted meets the requirements of the Act and the regulations in this part.

Subpart E—Qualified Agents, Brokers and Surety Companies for the Placing of Bonds

§ 2580.412–21 Corporate sureties holding grants of authority from the Secretary of the Treasury.

(a) The provisions of section 13 require that any surety company with which a bond is placed pursuant to that section must be a corporate surety which holds a grant of authority from the Secretary of the Treasury under the Act of July 30, 1947 (6 U.S.C. 6–13), as an acceptable surety on Federal bonds. The Act provides, among other things, that in order for a surety company to be eligible for such grant of authority, it must be incorporated under the laws of the United States or of any State and the Secretary of the Treasury shall be satisfied of certain facts relating to its authority and capitalization. Such grants of authority are evidenced by Certificates of Authority which are issued by the Secretary of the Treasury and which expire on the April 30 following the date of their issuance. A list of the companies holding such Certificates of Authority is published annually in the FEDERAL REGISTER, usually in May or June. Changes in the list, occurring between May 1 and April 30, either by addition to or removal from the list of companies, are also published in the FEDERAL REGISTER following each such change.

(b) Where a surety becomes insolvent and is placed in receivership, or if for any other reason the Secretary of the Treasury determines that its financial condition is not satisfactory to him and he revokes the authority of such company to act as an acceptable surety under the Act of July 30, 1947, the ''administrator'' of the insured plan shall, upon knowledge of such facts, be responsible for securing a new bond with an acceptable surety.

(c) In obtaining or renewing a bond, the plan administrator shall assure that the surety is one which satisfies the requirements of this section. If the bond is for a term of more than one year, the plan administrator, at the beginning of each reporting year, shall assure that the surety continues to satisfy the requirements of this subpart.

§ 2580.412–22 Interests held in agents, brokers and surety companies.

Section 13(c) prohibits the placing of bonds, required to be obtained pursuant to section 13, with any surety or other company, or through any agent or broker in whose business operations a plan or any party in interest in a plan has significant control or financial interest, direct or indirect. An interpretation of this section has been issued (§ 2580.412–36 of this chapter).

Subpart F—Exemptions

SOURCE: 28 FR 14410, Dec. 27, 1963, unless otherwise noted. Redesignated at 50 FR 26706, June 28, 1985.

BONDS PLACED WITH CERTAIN REINSURING COMPANIES

§ 2580.412–23 Exemption.

An exemption from the bonding requirements of the Welfare and Pension Plans Disclosure Act is granted by this section whereby bonding arrangements (which otherwise comply with the requirements of section 13 of the Act and the regulations issued thereunder) with companies authorized by the Secretary of the Treasury as acceptable reinsurers on Federal bonds will satisfy the bonding requirements of the Act.

§ 2580.412–24 Conditions of exemption.

(a) This exemption obtains only with respect to the requirement of section 13(a) of the Act that all bonds required thereunder shall have as surety thereon, a corporate surety company, which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury pursuant to the Act of July 30, 1947 (6 U.S.C. 6–13).

(b) The exemption is granted upon the condition that if for any reason the authority of any such company to act as an acceptable reinsuring company is terminated, the administrator of a plan insured with such company, shall, upon knowledge of such fact, be responsible for securing a new bond with a company acceptable under the Act and the exemptions issued thereunder.

(c) In obtaining or renewing a bond, the plan administrator shall ascertain that the surety is one which satisfies the requirements of the Act and the exemptions thereunder. If the bond is for a term of more than one year, the plan administrator, at the beginning of each reporting year, shall ascertain that the surety continues to do so.

BONDS PLACED WITH UNDERWRITERS AT LLOYDS, LONDON

§ 2580.412–25 Exemption.

An exemption from the bonding requirements of subsection 13(a) of the Welfare and Pension Plans Disclosure Act is granted by this section whereby arrangements (which otherwise comply with the requirements of section 13 of the Act and the regulations issued thereunder), with the Underwriters at Lloyds, London will satisfy the bonding requirements of the Act.

§ 2580.412–26 Conditions of exemption.

(a) This exemption obtains only with respect to the requirements of section 13(a) of the Act that all bonds required thereunder shall have as surety thereon, a corporate surety company, which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury, pursuant to the Act of July 30, 1947 (6 U.S.C. 6–13).

(b) This exemption is granted on the following conditions:

(1) Underwriters at Lloyds, London shall continue to be licensed in a state of the United States to enter into bonding arrangements of the type required by the Act.

(2) Underwriters at Lloyds, London, shall file with the Office of Pension and Welfare Benefit Programs two (2) copies of each annual statement required to be made to the Commissioner of Insurance of those states in which Underwriters at Lloyds, London are licensed. Copies of annual statements shall be filed with the Office of Pension and Welfare Benefit Programs within the same period required by the respective states.

(3) All bonding arrangements entered into by Underwriters at Lloyds, London under section 13 of the Act shall contain a ''Service of Suit Clause'' in substantial conformity with that set forth in the petition for exemption.

BANKING INSTITUTIONS SUBJECT TO FEDERAL REGULATION

§ 2580.412–27 Exemption.

An exemption from the bonding requirements of subsections 13 (a) and (b) of the Welfare and Pension Plans Disclosure Act is granted whereby banking institutions and trust companies specified in § 2580.412–28 are not required to comply with subsections 13 (a) and (b) of the Act, with respect to

welfare and pension benefit plans covered by the Act.

[34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

§ 2580.412–28 Conditions of exemption.

This exemption applies only to those banking institutions and trust companies subject to regulation and examination by the Comptroller of the Currency or the Board of Governors of the Federal Reserve System, or the Federal Deposit Insurance Corporation.

SAVINGS AND LOAN ASSOCIATIONS SUBJECT TO FEDERAL REGULATION

§ 2580.412–29 Exemption.

An exemption from the bonding requirements of subsections 13 (a) and (b) of the Welfare and Pension Plans Disclosure Act is granted whereby savings and loan associations (including building and loan associations, cooperative banks and homestead associations) specified in § 2580.412–30 are not required to comply with subsections 13 (a) and (b) of the Act, with respect to welfare and pension benefit plans covered by the Act for the benefit of their own employees, where such a savings and loan association is the administrator of such plans.

[32 FR 6840, May 4, 1967. Redesignated at 50 FR 26706, June 28, 1985]

§ 2580.412–30 Conditions of exemption.

This exemption applies only to those savings and loan associations (including building and loan associations, cooperative banks and homestead associations) subject to regulation and examination by the Federal Home Loan Bank Board.

[32 FR 6840, May 4, 1967. Redesignated at 50 FR 26706, June 28, 1985]

INSURANCE CARRIERS, SERVICE AND OTHER SIMILAR ORGANIZATIONS

§ 2580.412–31 Exemption.

An exemption from the bonding requirements of subsection 13 (a) and (b) of the Welfare and Pension Plans Disclosure Act is granted whereby any insurance carrier or service or other similar organization specified in § 2580.412–32 is not required to comply with subsections 13 (a) and (b) of the Act with respect to any welfare or pension benefit plan covered by the Act which is established or maintained for the benefit of persons other than the employees of such insurance carrier or service or other similar organization.

[34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

§ 2580.412–32 Conditions of exemption.

This exemption applies only to those insurance carriers, service or other similar organizations providing or underwriting welfare or pension plan benefits in accordance with State law.

[34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

Subpart G—Prohibition Against Bonding by Parties Interested in the Plan

SOURCE: 28 FR 14412, Dec. 27, 1963, unless otherwise noted. Redesignated at 50 FR 26706, June 28, 1985.

§ 2580.412–33 Introductory statement.

(a) This part discusses the meaning and scope of section 13(c) of the Welfare and Pension Plans Disclosure Act of 1958 (76 Stat. 39, 29 U.S.C. 308d(c)) (hereinafter referred to as the Act). This provision makes it unlawful ''for any person to procure any bond [required by the Act] from any surety or other company or through any agent or broker in whose business operations such plan or any party in interest in such plan has any significant control or financial interest, direct or indirect.'' Because the prohibition contained in this provision is broadly stated, it becomes a matter of importance to determine more specifically the types of arrangements intended to be prohibited.

(b) The provisions of section 13 of the Act, including 13(c) are subject to the general investigatory authority of the Director, Office of Labor-Management and Welfare-Pension Reports, embodied in section 9 of the Act. The correctness of an interpretation of these provisions can be determined finally and authoritatively only by the courts. It is necessary, however, for the Labor-Management Services Administrator to reach

informed conclusions as to the meaning of the law to enable him to carry out his statutory duties of administration and enforcement. The interpretations of the Labor-Management Services Administrator contained in this part, which are issued upon the advice of the Solicitor of Labor, indicate the construction of the law which will guide the Labor-Management Services Administrator in performing his duties unless and until he is directed otherwise by authoritative ruling of the courts or unless and until he subsequently decides that his prior interpretation is incorrect. Under section 12 of the Act, the interpretations contained in this part, if relied upon in good faith, will constitute a defense in any action or proceeding based on any Act or omission in alleged violation of section 13(c) of the Act. The omission, however to discuss a particular problem in this part, or in interpretations supplementing it, should not be taken to indicate the adoption of any position by the Labor-Management Services Administrator with respect to such problem or to constitute an administrative interpretation or practice. Interpretations of the Labor-Management Services Administrator with respect to 13(c) are set forth in this part to provide those affected by the provisions of the Act with ''a practical guide * * * as to how the office representing the public interest in its enforcement will seek to apply it'' (*Skidmore* v. *Swift & Co.*, 323 U.S. 134, 138).

(c) To the extent that prior opinions and interpretations relating to 13(c) are inconsistent with the principles stated in this part, they are hereby rescinded and withdrawn.

§ 2580.412–34 General.

The purpose of section 13(c), as shown by its legislative history, is similar to a closely related provision contained in section 502(a) of the Labor-Management Reporting and Disclosure Act of 1959 (73 Stat. 536; 29 U.S.C. 502(a)). The fundamental purpose of Congress under 13(c) is to insure against potential abuses arising from significant financial or other influential interests affecting the objectivity of the plan or parties in interest in the plan and agents, brokers, or surety or other companies, in securing and providing the bond specified in section 13(a). As will be explained more fully below, this prohibition, however, was not intended to preclude the placing of bonds through or with certain parties in interest in plans which provide a variety of services to the plan, one of which is a bonding service.

§ 2580.412–35 Disqualification of agents, brokers and sureties.

Since 13(c) is to be construed as disqualifying any agent, broker, surety or other company from having a bond placed through or with it, if the plan or any party in interest in the plan has a significant financial interest or control in such agent, broker, surety or other company, a question of fact will necessarily arise in many cases as to whether the financial interest or control held is sufficiently significant to disqualify the agent, broker or surety. Although no rule of guidance can be established to govern each and every case in which this question arises, in general, the essential test is whether the existing financial interest or control held is incompatible with an unbiased exercise of judgment in regard to procuring the bond or bonding the plan's personnel. In regard to the foregoing, it is also to be pointed out that lack of knowledge or consent on the part of persons responsible for procuring bonds with respect to the existence of a significant financial interest or control rendering the bonding arrangement unlawful will not be deemed a mitigating factor where such persons have failed to make a reasonable examination into the pertinent circumstances affecting the procuring of the bond.

§ 2580.412–36 Application of 13(c) to "party in interest".

(a) Under 13(c), an agent, broker or surety or other company is disqualified from having a bond placed through or with it if a ''party in interest'' in the plan has any significant control or financial interest in such agent, broker, surety or other company. Section 3(13) of the Act defines the term ''party in interest'' to mean ''any administrator, officer, trustee, custodian, counsel, or

employee of any employee welfare benefit plan or a person providing benefit plan services to any such plan, or an employer any of whose employees are covered by such a plan or officer or employee or agent of such employer, or an officer or agent or employee of an employee organization having members covered by such plan.''

(b) A basic question presented is whether the effect of 13(c) is to prohibit persons from placing a bond through or with any ''party in interest'' in the plan. The language used in 13(c) appears to indicate that in this connection the intent of Congress was to eliminate those instances where the existing financial interest or control held by the ''party in interest'' in the agent, broker, surety or other company is incompatible with an unbiased exercise of judgment in regard to procuring the bond or bonding the plan's personnel. Accordingly, not all parties in interest are disqualified from procuring or providing bonds for the plan. Thus where a ''party in interest'' or its affiliate provides multiple benefit plan services to plans, persons are not prohibited from availing themselves of the bonding services provided by the ''party in interest'' or its affiliate merely because the plan has already availed itself, or will avail itself, of other services provided by the ''party in interest.'' In this case, it is inherent in the nature of the ''party in interest'' or its affiliate as an individual or organization providing multiple benefit plan services, one of which is a bonding service, that the existing financial interest or control held is not, in and of itself, incompatible with an unbiased exercise of judgment in regard to procuring the bond or bonding the plan's personnel. In short, there is no distinction between this type of relationship and the ordinary arm's length business relationship which may be established between a plan-customer and an agent, broker or surety company, a relationship which Congress could not have intended to disturb. On the other hand, where a ''party in interest'' in the plan or an affiliate does not provide a bonding service as part of its general business operations, 13(c) would prohibit any person from procuring the bond through or with any agent, broker, surety or other company, with respect to which the ''party in interest'' has any significant control or financial interest, direct or indirect. In this case, the failure of the ''party in interest'' or its affiliate to provide a bonding service as part of its general business operations raises the posibility of less than an arm's length business relationship between the plan and the agent, broker, surety or other company since the objectivity of either the plan or the agent, broker or surety may be influenced by the ''party in interest''.

(c) The application of the principles discussed in this section is illustrated by the following examples:

Example (*1*). B, a broker, renders actuarial and consultant service to plan P. B has also procured a group life insurance policy for plan P. B may also place a bond for P with surety company S, provided that neither B nor P has any significant control or financial interest, direct or indirect, in S and provided that neither P nor any other ''party in interest'' in P, e.g., an officer of the plan, has any significant control or financial interest, direct or indirect, in B or S.

Example (*2*). I, a life insurance company, has provided a group life insurance policy for plan P. I is affiliated with S, a surety company, and has a significant financial interest or control in S. P is not prohibited from obtaining a bond from S since I's affiliation with S does not ordinarily, in and of itself, affect the objectivity of P in procuring the bond or the objectivity of S in bonding P's personnel. However, if any other ''party in interest'' as defined in section 3(13) of the Act, such as the employer whose employees are covered by P, should have a significant financial interest or control in S, S could not write the bond for P, since the employer's interest affects the objectivity of P and S.

SUBCHAPTER J—FIDUCIARY RESPONSIBILITY UNDER THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986

PART 2582—RULES AND REGULATIONS FOR FIDUCIARY RESPONSIBILITY

Subpart A—Temporary Bonding Rules

Sec.
2582.8478–1 Temporary bonding requirements.
2582.8478–2 Amount of the bond.

Subpart B—Permanent Bonding Rules

2582.8478–3 Permanent bonding requirements.
2582.8478–4 Permanent amount of the bond.

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Subpart A—Temporary Bonding Rules

§ 2582.8478–1 Temporary bonding requirements.

(a) *General*. Pending the issuance of permanent regulations under section 8478 of the Federal Employees' Retirement System Act of 1986 (FERSA), any fiduciary with respect to the Thrift Savings Fund (Fund) established under FERSA or any person who handles funds or other property of the Fund, shall be deemed to be in compliance with the bonding requirements of section 8478 of FERSA if he or she is bonded in compliance with the temporary bonding regulations under section 412 of the Employee Retirement Income Security Act of 1974 (ERISA) set forth in part 2580 of title 29 of the Code of Federal Regulations.

(b) *Application of ERISA temporary bonding rules*. For purposes of this section:

(1) Any reference to section 13 of the Welfare and Pension Plans Disclosure Act, as amended (WPPDA), or any section thereof in the ERISA temporary bonding regulations shall be deemed to refer to section 8478 of FERSA or the corresponding subsection thereof;

(2) Where the particular phrases set forth in FERSA are not identical to the phrases in the WPPDA, ERISA or the ERISA temporary bonding regulations, the phrases appearing in FERSA shall be substituted by operation of law; and

(3) Where the phrases are identical but the meaning is different, the meaning given such phrases by FERSA shall govern. For example, the phrase ''every administrator, officer and employee of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handles funds or other property of such plan'' which appears in the WPPDA and in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, ''each fiduciary and each person who handles funds or property of the Thrift Savings Fund,'' which is the term appearing in section 8478 of FERSA; the terms ''employee benefit plan'' and ''plan'' which appear in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, ''Thrift Savings Fund''; and the term ''reporting year of the plan'' which appears in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, ''fiscal year of the Thrift Savings Fund.''

(c) *Effectiveness*. This section is effective until the earlier of the date of issuance by the Secretary of Labor of permanent regulations under section 8478 of FERSA or December 31, 1989.

[52 FR 35866, Sept. 23, 1987]

§ 2582.8478–2 Amount of the bond.

(a) *General*. Under the authority of section 8478(b)(1) of the Federal Employees' Retirement System Act of 1986 (FERSA), the amount of a bond for each person, group or class to be bonded shall not be less than 10 percent of the amount of funds handled by such person, group or class with respect to any fiscal year of the Fund. In no case shall such bond be less than $1,000 nor more than $500,000. However, the Secretary of Labor reserves the authority under section 8478(b)(1) of FERSA to prescribe an amount in excess of

$500,000, after due notice and opportunity for hearing to all interested parties, and other consideration of the record.

(b) *Effectiveness*. This section shall remain in effect until it is amended or withdrawn in accordance with section 8478(b)(1) of FERSA, but in no event shall this section remain in effect beyond December 31, 1989.

[52 FR 35866, Sept. 23, 1987, as amended at 54 FR 53609, Dec. 29, 1989]

Subpart B—Permanent Bonding Rules

§ 2582.8478–3 Permanent bonding requirements.

(a) *General*. Any fiduciary with respect to the Thrift Savings Fund (Fund) established under the Federal Employees' Retirement System Act of 1986 (FERSA) or any person who handles funds or other property of the Fund shall be deemed to be in compliance with the bonding requirements of section 8478 of FERSA if he or she is bonded in compliance with the temporary bonding regulations under section 412 of the Employee Retirement Income Security Act of 1974 (ERISA) set forth in part 2580 of title 29 of the Code of Federal Regulations.

(b) *Application of ERISA temporary bonding rules*. For purposes of this section:

(1) Any reference to section 13 of the Welfare and Pension Plans Disclosure Act, as amended (WPPDA), or any section thereof in the ERISA temporary bonding regulations shall be deemed to refer to section 8478 of FERSA or the corresponding subsection thereof;

(2) Where the particular phrases set forth in FERSA are not identical to the phrases in the WPPDA, ERISA or the ERISA temporary bonding regulations, the phrases appearing in FERSA shall be substituted by operation of law; and

(3) Where the phrases are identical but the meaning is different, the meaning given such phrases by FERSA shall govern. For example, the phrase ''every administrator, officer and employee of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handles funds or other property of such plan'' which appears in the WPPDA and in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section ''each fiduciary and each person who handles funds or other property of the Thrift Savings Fund,'' which is the term appearing in section 8478 of FERSA; the terms ''employee benefit plan'' and ''plan'' which appear in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, ''Thrift Savings Fund''; and the term ''reporting year of the plan'' which appears in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, ''fiscal year of the Thrift Savings Fund.''

(c) *Effective date*. This section is effective January 1, 1990.

[54 FR 53609, Dec. 29, 1989]

§ 2582.8478–4 Permanent amount of the bond.

(a) *General*. Under the authority of section 8478(b)(1) of the Federal Employees' Retirement System Act of 1986 (FERSA), the amount of a bond for each person, group or class to be bonded shall not be less than 10 percent of the amount of funds handled by such person, group or class with respect to any fiscal year of the Fund. In no case shall such bond be less than $1,000 nor more than $500,000. However, the Secretary of Labor reserves the authority under section 8478(b)(1) of FERSA to prescribe an amount in excess of $500,000, after due notice and opportunity for hearing to all interested parties, and other consideration of the record.

(b) *Effective date*. This section shall become effective January 1, 1990, and remain in effect until it is amended or withdrawn in accordance with section 8478(b)(1) of FERSA.

[54 FR 53609, Dec. 29, 1989]

PART 2584—RULES AND REGULATIONS FOR THE ALLOCATION OF FIDUCIARY RESPONSIBILITY

Sec.

2584.8477(e)–1 General.
2584.8477(e)–2 Allocation of fiduciary duties.
2584.8477(e)–3 Procedures for allocation.

2584.8477(e)–4 Revocation and termination of allocation.
2584.8477(e)–5 Effect of allocation.
2584.8477(e)–6 Definitions.
2584.8477(e)–7 Effective date.

AUTHORITY: 5 U.S.C. 8477(e)(1)(E) and Secretary's Order 1–87, 52 FR 13139 (April 21, 1987).

SOURCE: 53 FR 52687, Dec. 29, 1988, unless otherwise noted.

§ 2584.8477(e)–1 General.

5 U.S.C. 8477(e)(1)(E) provides that any fiduciary with respect to the Thrift Savings Fund of the Federal Employees Retirement System who allocates a fiduciary responsibility to another person pursuant to procedures prescribed by the Secretary of Labor shall not be liable for an act or omission of such person except in specified circumstances. This part sets forth the procedures which have been prescribed by the Secretary of Labor for the allocation of fiduciary responsibilities.

§ 2584.8477(e)–2 Allocation of fiduciary duties.

(a) The fiduciary duties of the Board as set forth at 5 U.S.C. 8472 may not be allocated to any person other than a member or members of the Board.

(b) The Executive Director may allocate authority and responsibility for the investment and management of the Fixed Income Investment Fund to a qualified professional asset manager(s).

(c) The Executive Director may allocate authority and responsibility for the investment and management of the Government Securities Investment Fund, the Common Stock Index Investment Fund, the International Stock Index Investment Fund and the Small Capitalization Stock Index Investment Fund to an investment manager(s).

(d) Notwithstanding any other provision of this part, no allocation may be made which would constitute:

(1) A violation of an express policy of the Board; or

(2) An invalid delegation according to the Act or any other law.

(e) Except as provided in this part, no person who has or may acquire fiduciary responsibility in connection with the Thrift Savings Fund may allocate such responsibility to another person.

[53 FR 52687, Dec. 29, 1988, as amended at 65 FR 34394, May 30, 2000]

§ 2584.8477(e)–3 Procedures for allocation.

(a) Any allocation made by the Board must—

(1) Be authorized by the concurring vote of a majority of the total membership of the Board;

(2) Be made in writing, signed by the Chairman of the Board and acknowledged in writing by the receiving Board member or members;

(3) Set forth the duties and responsibilities allocated, either in the body of the document or by reference to another document existing at the time of the allocation; and

(4) Be communicated in an appropriate written form to the Executive Director, the participants and the beneficiaries of the Thrift Savings Fund.

(b) Any allocation made by the Executive Director must—

(1) Be made in writing, signed by the Executive Director and acknowledged in writing by the receiving fiduciary;

(2) Set forth the duties and responsibilities allocated, either in the body of the document or by reference to another document existing at the time of the allocation; and

(3) Be communicated in an appropriate written form to the participants and beneficiaries of the Thrift Savings Fund.

§ 2584.8477(e)–4 Revocation and termination of allocation.

(a) Any allocation made pursuant to this part must be revocable at will by the allocating fiduciary, subject only to notice which is reasonable under the circumstances.

(b) Any revocation by the allocating fiduciary or termination of an allocation by the fiduciary to whom duties have been allocated must set forth in writing the duties and responsibilities as to which the revocation or termination is effective, either in the body of the document or by reference to another document existing at the time of the revocation or termination.

(c) Any revocation of an allocation must—

(1) In the case of an allocation which was made by the Board, be authorized by the concurring vote of a majority of the total membership of the Board and be signed by the Chairman of the Board, or

(2) In the case of an allocation which was made by the Executive Director, be signed by the Executive Director.

(d) Any termination of an allocation, to be effective, must—

(1) In the case of an allocation which was made by the Board, be signed by the terminating fiduciary and acknowledged in writing by the Chairman of the Board, or

(2) In the case of an allocation which was made by the Executive Director, be signed by the terminating fiduciary and acknowledged in writing by the Executive Director.

(e) Any revocation or termination of an allocation must be communicated by the Executive Director in an appropriate written form to the participants and beneficiaries of the Thrift Savings Fund in a manner which identifies the person(s) assuming the responsibilities which were the subject of the revocation or termination.

§ 2584.8477(e)–5 Effect of allocation.

Where fiduciary responsibility has been allocated to another person or persons pursuant to the procedures contained in this part, the allocating fiduciary shall not be liable for any act or omission of such person or persons unless:

(a) The allocating fiduciary has violated 5 U.S.C. 8477(b) with respect to—

(1) The allocation or the continuation of the allocation,

(2) The implementation of these procedures, or

(3) The duty to monitor the performance of such person or persons in a reasonable manner during the life of the allocation, or

(b) The allocating fiduciary would otherwise be liable in accordance with 5 U.S.C. 8477(e)(1)(D).

§ 2584.8477(e)–6 Definitions.

As used in this part:

(a) *Act* means the Federal Employees' Retirement System Act of 1986, 5 U.S.C. 8401 *et seq.* (Supp. III 1997);

(b) *Board* means the Federal Retirement Thrift Investment Board established pursuant to 5 U.S.C. 8472;

(c) *Common Stock Index Investment Fund* means the fund established under 5 U.S.C. 8438(b)(1)(C);

(d) *Executive Director* means the executive director of the Federal Retirement Thrift Investment Board as appointed pursuant to 5 U.S.C. 8474;

(e) *Fiduciary duty* and *fiduciary responsibility* mean any duty or responsibility which involves the exercise of discretionary authority or discretionary control over—

(1) The management or disposition of the assets of the Thrift Savings Fund, or

(2) The administration of the Thrift Savings Fund;

(f) *Fixed Income Investment Fund* means the fund established under 5 U.S.C. 8438(b)(1)(B);

(g) *Government Securities Investment Fund* means the fund established under 5 U.S.C. 8438(b)(1)(A);

(h) *International Stock Index Investment Fund* means the fund established under 5 U.S.C. 8438(b)(1)(E);

(i) *Investment manager* means any fiduciary who—

(1) Has the power to manage, acquire or dispose of any asset of the plan,

(2) Is:

(i) Registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1),

(ii) Not registered as an investment adviser under such Act by reason of paragraph (1) of section 203A(a) of such Act (15 U.S.C. 80b–3a) but is registered as an investment adviser under the laws of the state (referred to in such paragraph (1)) in which it maintains its principal office and place of business, and, at the time the fiduciary last filed the registration form most recently filed by the fiduciary with such state in order to maintain the fiduciary's registration under the laws of such state, also filed a copy of such form with the Secretary of Labor,

(iii) A bank, as defined in that Act, or

(iv) An insurance company qualified to perform services described in paragraph (i)(1) of this section under the laws of more than one state, and

(3) Has acknowledged in writing that he or she is a fiduciary with respect to the Thrift Savings Fund;

(j) *Qualified professional asset manager* has the meaning which is prescribed at 5 U.S.C. 8438(a)(7);

(k) *Small Capitalization Stock Index Investment Fund* means the fund established under 5 U.S.C. 8438(b)(1)(D);

(l) *Thrift Savings Fund* means the fund established under 5 U.S.C. 8437.

[53 FR 52687, Dec. 29, 1988, as amended at 65 FR 34394, May 30, 2000]

§ 2584.8477(e)–7 Effective date.

This section is effective December 29, 1988, and liability for any transaction which occurs on or after this date will be governed by this section only. In accordance with section 114(a) of Pub. L. 99–556, the interim regulations promulgated by the Board appearing at title 5, CFR, chapter VI, §§ 1660.1 through 1660.5 will no longer be effective as of December 29, 1988. Liability for transactions which occur before the effective date of this regulation, however, will continue to be governed by allocations made both during the statutorily defined effective period of the previously cited interim regulations and pursuant to the requirements of those regulations.

SUBCHAPTER K—ADMINISTRATION AND ENFORCEMENT UNDER THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986

PART 2589—RULES AND REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT

AUTHORITY: Sec. 8477(e)(1)(B) and (f) of FERSA (sec. 101, Pub. L. 99–335, 100 Stat. 584, 586, 5 U.S.C. 8477(e)(1)(B) and (f), and Secretary's Order 1–87, 52 FR 13139 (Apr. 21, 1987).

SOURCE: 54 FR 32636, Aug. 9, 1989, unless otherwise noted.

§ 2589.1 Civil penalties under section 8477(e)(1)(B) of FERSA.

(a) Section 8477(e)(1)(B) of FERSA, 5 U.S.C. 8477(e)(1)(B), permits the Secretary of Labor to assess a civil penalty against a party in interest who engages in a prohibited transaction with respect to the Thrift Savings Fund. The initial penalty under section 8477(e)(1)(B) is five percent of the ''amount involved'' in each such transaction for each year or part thereof during which the prohibited transaction continues. However, if the prohibited transaction is not corrected during the ''correction period,'' the civil penalty may be in an amount not more than 100% of the ''amount involved.'' The Department of Labor will apply the definitions set out in § 2560.502i–1(b) through (e) of this chapter of title 29 (civil penalties under section 502(i) of ERISA) in determining the ''amount involved,'' ''correction,'' ''correction period,'' and for computation of the section 8477(e)(1)(B) penalty.

(b) The rules of practice set forth in §§ 2570.1–2570.12 of part 2570, subpart A of subchapter G of this chapter of title 29 (procedures for the assessment of civil sanctions under ERISA section 502(i)) are applicable to prohibited transaction penalty proceedings under FERSA section 8477(e)(1)(B).

SUBCHAPTER L—HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLAN REQUIREMENTS

Subpart A—Continuation Coverage, Qualified Medical Child Support Orders, Coverage for Adopted Children

Sec.
2590.609–1 [Reserved]
2590.609–2 National Medical Support Notice.

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

2590.701–1 Basis and scope.
2590.701–2 Definitions.
2590.701–3 Limitations on preexisting condition exclusion period.
2590.701–4 Rules relating to creditable coverage.
2590.701–5 Certification and disclosure of previous coverage.
2590.701–6 Special enrollment periods.
2590.701–7 HMO affiliation period as alternative to preexisting condition exclusion.
2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.
2590.703 Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements. [Reserved]

Subpart C—Other Requirements

2590.711 Standards relating to benefits for mothers and newborns.
2590.712 Parity in the application of certain limits to mental health benefits.

Subpart D—General Provisions

2590.731 Preemption; State flexibility; construction.
2590.732 Special rules relating to group health plans.
2590.734 Enforcement. [Reserved]
2590.736 Applicability dates.

AUTHORITY: 29 U.S.C. 1027, 1059, 1135, 1171, 1194; Sec. 4301, Pub. L. 103–66, 107 Stat. 372 (29 U.S.C. 1169); Sec. 101, Pub. Law 104–191, 101 Stat. 1936 (29 U.S.C. 1181); Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

SOURCE: 62 FR 16941, Apr. 8, 1997, unless otherwise noted.

Subpart A—Continuation Coverage, Qualified Medical Child Support Orders, Coverage for Adopted Children

§ 2590.609–1 [Reserved]

§ 2590.609–2 National Medical Support Notice.

(a) This section promulgates the National Medical Support Notice (the Notice), as mandated by section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105–200). If the Notice is appropriately completed and satisfies paragraphs (3) and (4) of section 609(a) of the Employee Retirement Income Security Act (ERISA), the Notice is deemed to be a qualified medical child support order (QMCSO) pursuant to ERISA section 609(a)(5)(C). Section 609(a) of ERISA delineates the rights and obligations of the alternate recipient (child), the participant, and the group health plan under a QMCSO. A copy of the Notice is available on the Internet at http://www.dol.gov/dol/pwba.

(b) For purposes of this section, a plan administrator shall find that a Notice is appropriately completed if it contains the name of an Issuing Agency, the name and mailing address (if any) of an employee who is a participant under the plan, the name and mailing address of one or more alternate recipient(s) (child(ren) of the participant) (or the name and address of a substituted official or agency which has been substituted for the mailing address of the alternate recipient(s)), and identifies an underlying child support order.

(c)(1) Under section 609(a)(3)(A) of ERISA, in order to be qualified, a medical child support order must clearly specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may

be substituted for the mailing address of any such alternate recipient. Section 609(a)(3)(B) of ERISA requires a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined. Section 609(a)(3)(C) of ERISA requires that the order specify the period to which such order applies.

(2) The Notice satisfies ERISA section 609(a)(3)(A) by including the necessary identifying information described in § 2590.609–2(b).

(3) The Notice satisfies ERISA section 609(a)(3)(B) by having the Issuing Agency identify either the specific type of coverage or all available group health coverage. If an employer receives a Notice that does not designate either specific type(s) of coverage or all available coverage, the employer and plan administrator should assume that all are designated. The Notice further satisfies ERISA section 609(a)(3)(B) by instructing the plan administrator that if a group health plan has multiple options and the participant is not enrolled, the Issuing Agency will make a selection after the Notice is qualified, and, if the Issuing Agency does not respond within 20 days, the child will be enrolled under the plan's default option (if any).

(4) Section 609(a)(3)(C) of ERISA is satisfied because the Notice specifies that the period of coverage may only end for the alternate recipient(s) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.

(d)(1) Under ERISA section 609(a)(4), a qualified medical child support order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act, 42 U.S.C. 1396g–1.

(2) The Notice satisfies the conditions of ERISA section 609(a)(4) because it requires the plan to provide to an alternate recipient only those benefits that the plan provides to any dependent of a participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of a State law described in such section 1908.

(e) For the purposes of this section, an ''Issuing Agency'' is a State agency that administers the child support enforcement program under Part D of Title IV of the Social Security Act.

[65 FR 82142, Dec. 27, 2000]

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

SOURCE: 62 FR 16941, Apr. 8, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000, unless otherwise noted.

§ 2590.701–1 Basis and scope.

(a) *Statutory basis*. This subpart implements part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended (hereinafter ERISA or the Act).

(b) *Scope*. A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this subpart. This subpart A sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

(5) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

§ 2590.701–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 2590.701 through 2590.734.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the Act, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and title XXII of the PHSA.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

Condition means a medical condition.

Creditable coverage means creditable coverage within the meaning of § 2590.701–4(a).

Enroll means to become covered for benefits under a group health plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date* and *first day of coverage*) are set forth in § 2590.701–3(a)(2) (i) and (ii).

Excepted benefits means the benefits described as excepted in § 2590.732(b).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Act). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHSA);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited duration insurance. For this purpose, short-term, limited duration insurance means health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is within 12 months of the date such contract becomes effective. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHSA, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Internal Revenue Code (Code) means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a health insurance issuer.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 2590.701–3(a)(2) (iii) and (iv).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible/limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means *public health plan* within the meaning of § 2590.701–4(a)(1)(ix).

Public Health Service Act (PHSA) means the Public Health Service Act (42 U.S.C. 201, *et seq.)*.

Significant break in coverage means a significant break in coverage within the meaning of § 2590.701–4(b)(2)(iii).

Special enrollment date means a special enrollment date within the meaning of § 2590.701–6(d).

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a State health benefits risk pool within the meaning of § 2590.701–4(a)(1)(vii).

Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

[62 FR 16941, Apr. 8, 1997; 62 FR 31692, June 10, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000]

§ 2590.701–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *In general.* Subject to paragraph (b) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(1)(i) are illustrated by the following examples:

Example 1. (i) Individual *A* is treated for a medical condition 7 months before the enrollment date in Employer *R*'s group health plan. As part of such treatment, *A*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation. *A* does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *A* or received by *A* during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan.

(ii) In this *Example 1,* Employer *R*'s plan may not impose a preexisting condition exclusion period with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 2. (i) Same facts as *Example 1,* except that Employer *R*'s plan learns of the condition and attaches a rider to *A*'s policy excluding coverage for the condition. Three months after enrollment, *A*'s condition recurs, and Employer *R*'s plan denies payment under the rider.

(ii) In this *Example 2,* the rider is a preexisting condition exclusion and Employer *R*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 3. (i) Individual *B* has asthma and is treated for that condition several times during the 6-month period before *B*'s enrollment date in Employer *S*'s plan. The plan imposes a 12-month preexisting condition exclusion. *B* has no prior creditable coverage to reduce the exclusion period. Three months after the enrollment date, *B* begins coverage under Employer *S*'s plan. Two months later, *B* is hospitalized for asthma.

(ii) In this *Example 3,* Employer *S*'s plan may exclude payment for the hospital stay and the physician services associated with this illness because the care is related to a medical condition for which treatment was

received by *B* during the 6-month period before the enrollment date.

Example 4. (i) Individual *D*, who is subject to a preexisting exclusion imposed by Employer *U*'s plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) In this *Example 4*, the leg fracture is not a condition related to *D*'s diabetes, even though poor circulation in *D*'s extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of *D*'s preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion (the look-forward rule).* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For purposes of this paragraph (a)(1)(ii), the 12-month and 18-month periods after the enrollment date are determined by reference to the anniversary of the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.* The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 2590.701–4. For purposes of this subpart the phrase ''days of creditable coverage'' has the same meaning as the phrase ''aggregate of the periods of creditable coverage'' as such phrase is used in section 701(a)(3) of the Act.

(iv) *Other standards.* See § 2590.702 for other standards that may apply with respect to certain benefits limitations or restrictions under a group health plan.

(2) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

(ii)(A) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

(B) The following example illustrates the rule of paragraph (a)(2)(ii)(A) of this section:

Example. (i) Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer's *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and then on October 14, 1998 completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) In this *Example*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the 6-month period in paragraph (a)(1)(i) would be the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan could apply a preexisting condition exclusion under paragraph (a)(1)(ii) would be the period from October 13, 1998 through October 12, 1999, and this period would be reduced under paragraph (a)(1)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

(iii) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(iv)(A) *Late enrollment* means enrollment under a group health plan other than on—

(*1*) The earliest date on which coverage can become effective under the terms of the plan; or

(*2*) A special enrollment date for the individual.

(B) If an individual ceases to be eligible for coverage under the plan by terminating employment, and then subsequently becomes eligible for coverage

under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(v) *Examples*. The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Employee *F* first becomes eligible to be covered by Employer *W's* group health plan on January 1, 1999, but elects not to enroll in the plan until April 1, 1999. April 1, 1999 is not a special enrollment date for *F*.

(ii) In this *Example 1*, *F* would be a late enrollee with respect to *F's* coverage that became effective under the plan on April 1, 1999.

Example 2. (i) Same as *Example 1*, except that *F* does not enroll in the plan on April 1, 1999 and terminates employment with Employer *W* on July 1, 1999, without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W's* plan effective on January 1, 2000.

(ii) In this *Example 2*, *F* would not be a late enrollee with respect to *F's* coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general*. Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under any creditable coverage. Accordingly, if a newborn is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child.

(ii) *Example*. The rule of this paragraph (b)(1) is illustrated by the following example:

Example. (i) Seven months after enrollment in Employer *W's* group health plan, Individual *E* has a child born with a birth defect. Because the child is enrolled in Employer *W's* plan within 30 days of birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W's* plan. Three months after the child's birth, *E* commences employment with Employer *X* and enrolls with the child in Employer *X's* plan 45 days after leaving Employer *W's* plan. Employer *X's* plan imposes a 12-month exclusion for any preexisting condition.

(ii) In this *Example*, Employer *X's* plan may not impose any preexisting condition exclusion with respect to *E's* child because the child was covered within 30 days of birth and had no significant break in coverage. This result applies regardless of whether *E's* child is included in the certificate of creditable coverage provided to *E* by Employer *W* indicating 300 days of dependent coverage or receives a separate certificate indicating 90 days of coverage. Employer *X's* plan may impose a preexisting condition exclusion with respect to *E* for up to 65 days for any preexisting condition of *E* for which medical advice, diagnosis, care, or treatment was recommended or received by *E* within the 6-month period ending on *E's* enrollment date in Employer *X's* plan.

(2) *Adopted children*. Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Break in coverage*. Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage.

(4) *Pregnancy*. A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) *Special enrollment dates*. For special enrollment dates relating to new dependents, see § 2590.701–6(b).

(c) *Notice of plan's preexisting condition exclusion*. A group health plan, and a health insurance issuer offering group health insurance under the plan, may not impose a preexisting condition exclusion with respect to a participant

or dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) as required by § 2590.701–5. The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

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§ 2590.701–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage*. For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.701–2.

(ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to part 7 of subtitle B of title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of title 10 U.S.C. chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26) of the Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHSA; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under title 5 U.S.C. chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) *Excluded coverage*. Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in § 2590.732).

(3) *Methods of counting creditable coverage*. For purposes of reducing any preexisting condition exclusion period, as provided under § 2590.701–3(a)(1)(iii), a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of an individual's creditable coverage by using the standard method described in paragraph (b) of this section, except that the plan, or issuer, may use the alternative method under

paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Definition of significant break in coverage.* A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of the Act and section 2723(b)(2)(iii) of the PHSA which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Examples.* The following examples illustrate how creditable coverage is counted in reducing preexisting condition exclusion periods under this paragraph (b)(2):

Example 1. (i) Individual *A* works for Employer *P* and has creditable coverage under Employer *P*'s plan for 18 months before *A*'s employment terminates. *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s group health plan, 64 days after the last date of coverage under Employer *P*'s plan. Employer *Q*'s plan has a 12-month preexisting condition exclusion period.

(ii) In this *Example 1*, because *A* had a break in coverage of 63 days, Employer *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion period.

Example 2. (i) Same facts as *Example 1*, except that *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s plan, on the 63rd day after the last date of coverage under Employer *P*'s plan.

(ii) In this *Example 2*, *A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, Employer *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period as it applies to *A*.

Example 3. (i) Same facts as *Example 1*, except that Employer *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this *Example 3*, the issuer that provides group health insurance to Employer *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break.

Example 4. (i) Same facts as *Example 3*, except that Employer *Q*'s plan is a self-insured plan, and, thus, is not subject to State insurance laws.

(ii) In this *Example 4*, the plan is not governed by the longer break rules under State insurance law and *A*'s previous coverage may be disregarded.

Example 5. (i) Individual *B* begins employment with Employer *R* 45 days after terminating coverage under a prior group health plan. Employer *R*'s plan has a 30-day waiting period before coverage begins. *B* enrolls in Employer *R*'s plan when first eligible.

(ii) In this *Example 5*, *B* does not have a significant break in coverage for purposes of determining whether *B*'s prior coverage must be counted by Employer *R*'s plan. *B* has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.

Example 6. (i) Individual *C* works for Employer *S* and has creditable coverage under Employer *S*'s plan for 200 days before *C*'s employment is terminated and coverage ceases. *C* is then unemployed and does not have any creditable coverage for 51 days before being hired by Employer *T*. Employer *T*'s plan has a 3-month waiting period. *C* works for Employer *T* for 2 months and then terminates employment. Eleven days after terminating employment with Employer *T*, *C* begins working for Employer *U*. Employer *U*'s plan

has no waiting period, but has a 6-month preexisting condition exclusion period.

(ii) In this *Example 6*, *C* does not have a significant break in coverage because, after disregarding the waiting period under Employer *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, C has 200 days of creditable coverage and Employer *U*'s plan may not apply its 6-month preexisting condition exclusion period with respect to *C*.

Example 7. (i) Individual *D* terminates employment with Employer *V* on January 13, 1998 after being covered for 24 months under Employer *V*'s group health plan. On March 17, the 63rd day without coverage, *D* applies for a health insurance policy in the individual market. *D*'s application is accepted and the coverage is made effective May 1.

(ii) In this *Example 7*, because *D* applied for the policy before the end of the 63rd day, and coverage under the policy ultimately became effective, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 107 days.

Example 8. (i) Same facts as *Example 7*, except that *D*'s application for a policy in the individual market is denied.

(ii) In this *Example 8*, because *D* did not obtain coverage following application, *D* incurred a significant break in coverage on the 64th day.

(v) *Other permissible counting methods*—(A) *Rule*. Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 2590.701–5), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example*. The rule of this paragraph (b)(2)(v) is illustrated by the following example:

Example. (i) Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraph (b)(2) (i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion period will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion period will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered*. Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application*. A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or policy. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits*. The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice*. If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure

statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 2590.701–5(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

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§ 2590.701–5 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a)(1) for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. For example, in the case of a group health plan funded through an insurance policy, the issuer is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if the plan actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements under this paragraph (a)(1) if any issuer offering the coverage is required to

provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and the plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A)(*1*) *Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide an automatic certificate for that period of creditable coverage for the individual under paragraph (a)(2)(ii) and (3) of this section. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request made under paragraph (b)(1) of this section (relating to the alternative method of counting creditable coverage). If the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy ceases, the issuer must provide an automatic certificate under paragraph (a)(2)(ii) of this section. An issuer may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the plan.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example.

Example. (i) A group health plan provides coverage under an HMO option and an indemnity option with a different issuer, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of the Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than

the time a notice is required to be furnished for a qualifying event under section 606 of the Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies this requirement if it provides the automatic certificate within a reasonable time period thereafter. In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the rules of this paragraph (a)(2):

Example 1. (i) Individual *A* terminates employment with Employer *Q*. *A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) In this *Example 2*, the automatic certificate may be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) Employer *R* maintains an insured group health plan. R has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation coverage provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) In this *Example 3*, the automatic certificate may be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, Employer *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to failure to make a timely payment for continuation coverage.

(ii) In this *Example 4*, the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for Employer *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*— (i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2) (ii) or (iii) of this section, if—

(*1*) An individual is entitled to receive a certificate;

(*2*) The individual requests that the certificate be sent to another plan or issuer instead of to the individual;

(*3*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (e.g., by telephone); and

(*4*) The receiving plan or issuer receives such information from the sending plan or issuer in such form within the time periods required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 2590.732. In addition,

the information in the certificate regarding coverage is not required to specify categories of benefits described in § 2590.701–4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c)(4) of this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption. See § 2590.701–3(b), under which such a child would not be subject to a preexisting condition exclusion.

(iii) *Transition rule for dependent coverage through June 30, 1998*—(A) *In general.* A group health plan or health insurance issuer that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (a)(3)(ii)(C) of this section by providing the name of the participant covered by the group health plan or health insurance issuer

and specifying that the type of coverage described in the certificate is for dependent coverage (e.g., family coverage or employee-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual pursuant to paragraph (a)(2)(iii) of this section, a plan or issuer must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (c)(4) of this section for special rules to demonstrate dependent status.

(D) *Duration.* This paragraph (a)(5)(iii) is only effective for certificates provided with respect to events occurring through June 30, 1998.

(6) *Special certification rules for entities not subject to part 7 of subtitle B of title I of the Act*—(i) *Issuers.* For special rules requiring that issuers, not subject to part 7 of subtitle B of title I of the Act, provide certificates consistent with the rules in this section, including issuers offering coverage with respect to creditable coverage described in sections 701(c)(1)(G) through (c)(1)(J) of the Act (coverage under a State health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act), see section 2721(b)(1)(B) of the PHSA (requiring certificates by issuers offering health insurance coverage in connection with a group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program (FEHBP)). In addition, see section 2743 of the PHSA applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, as described in the definition of *individual health insurance coverage* in § 2590.701–2, that is not provided by a group health plan or issuer offering health insurance in connection with a group health plan.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to part 7 of subtitle B of title I of the Act, provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHSA applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of PHSA (relating to Medicare, Medicaid, CHAMPUS, and Indian Health Service), section 2721(b)(1)(A) of the PHSA applicable to nonfederal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHSA applicable to nonfederal governmental plans that elect to be excluded from the requirements of subparts 1 through 3 of part A of title XXVII of the PHSA, and section 9805(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage*—(1) *In general.* If an individual enrolls in a group health plan with respect to which the plan, or issuer, uses the alternative method of counting creditable coverage described in § 2590.701–4(c) the individual provides a certificate of coverage under paragraph (a) of this section, and the plan or issuer in which the individual enrolls so requests, the entity that issued the certificate (the prior entity) is required to disclose promptly to a requesting plan or issuer (the requesting entity) the information set forth in paragraph (b)(2) of this section.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any

such category. The prior entity is required to disclose promptly to the requesting entity the creditable coverage information so requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (b) of this section may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *In general.* The rules in this paragraph (c) implement section 701(c)(4) of the Act, which permits individuals to establish creditable coverage through means other than certificates, and section 701(e)(3) of the Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time period;

(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The coverage is for a period before July 1, 1996;

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage*—(i) *Consideration of evidence.* A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(2) are illustrated by the following example:

Example. (i) Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. Employer *X*'s

group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, Employer *W*, and requests a certificate. However, *F* (and Employer *X*'s plan, on *F*'s behalf) is unable to obtain a certificate from Employer *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under Employer *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from Employer *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under Employer *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(3) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(4) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(d) *Determination and notification of creditable coverage*—(1) *Reasonable time period.* In the event that a group health plan or health insurance issuer offering group health insurance coverage receives information under paragraph (a) of this section (certifications), paragraph (b) of this section (disclosure of information relating to the alternative method), or paragraph (c) of this section (other evidence of creditable coverage), the entity is required, within a reasonable time period following receipt of the information, to make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with paragraph (d)(2) of this section. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.

(2) *Notification to individual of period of preexisting condition exclusion.* A plan or issuer seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied. In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this paragraph (d) or paragraph (c) of this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(i) A notice of such reconsideration, as described in this paragraph (d), is provided to the individual; and

(ii) Until the final determination is made, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(3) *Examples.* The following examples illustrate this paragraph (d):

Example 1. (i) Individual *G* is hired by Employer *Y*. Employer *Y*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. Employer *Y*'s plan determines that *G* is subject to a 4-month preexisting condition exclusion, based on a certificate of creditable coverage that is provided by *G* to Employer *Y*'s plan indicating 8

months of coverage under *G*'s prior group health plan.

(ii) In this *Example 1*, Employer *Y*'s plan must notify *G* within a reasonable period of time following receipt of the certificate that *G* is subject to a 4-month preexisting condition exclusion beginning on *G*'s enrollment date in *Y*'s plan.

Example 2. (i) Same facts as in *Example 1*, except that Employer *Y*'s plan determines that *G* has 14 months of creditable coverage based on *G*'s certificate indicating 14 months of creditable coverage under *G*'s prior plan.

(ii) In this *Example 2*, Employer *Y*'s plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

Example 3. (i) Individual *H* is hired by Employer *Z*. Employer *Z*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. *H* develops an urgent health condition before receiving a certificate of prior coverage. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf.

(ii) In this *Example 3*, Employer *Z*'s plan must review the evidence presented by *H*. In addition, the plan must make a determination and notify *H* regarding any preexisting condition exclusion period that applies to *H* (and the basis of such determination) within a reasonable time period following receipt of the evidence that is consistent with the urgency of *H*'s health condition (this determination may be modified as permitted under paragraph (d)(2) of this section).

(Approved by the Office of Management and Budget under control numbers 1210–0102 and 1210–0103)

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§ 2590.701–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general*. A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, is required to permit employees and dependents described in paragraph (a) (2), (3), or (4) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(5) of this section are satisfied and the enrollment is requested within the period described in paragraph (a)(6) of this section. The enrollment is effective at the time described in paragraph (a)(7) of this section. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee only*. An employee is described in this paragraph (a)(2) if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was declined by the employee, the employee was covered under another group health plan or had other health insurance coverage.

(3) *Special enrollment of dependents only*. A dependent is described in this paragraph (a)(3) if the dependent is a dependent of an employee participating in the plan, the dependent is eligible, but not enrolled, for coverage under the terms of the plan, and, when enrollment was previously offered under the plan and was declined, the dependent was covered under another group health plan or had other health insurance coverage.

(4) *Special enrollment of both employee and dependent*. An employee and any dependent of the employee are described in this paragraph (a)(4) if they are eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee or dependent under the plan and was declined, the employee or dependent was covered under another group health plan or had other health insurance coverage.

(5) *Conditions for special enrollment*. An employee or dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

(i) When the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment. This paragraph (a)(5)(i) applies only if—

(A) The plan required such a statement when the employee declined enrollment; and

(B) The employee is provided with notice of the requirement to provide

the statement in this paragraph (a)(5)(i) (and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment.

(ii)(A) When the employee declined enrollment for the employee or dependent under the plan, the employee or dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or

(B) If the other coverage that applied to the employee or dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage has been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an employee's coverage ceases following a termination of employment and the employee is eligible for but fails to elect COBRA continuation coverage, this is treated as a loss of eligibility under this paragraph (a)(5)(ii)(B). However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, for purposes of this paragraph (a)(5)(ii)(B), employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(6) *Length of special enrollment period.* The employee is required to request enrollment (for the employee or the employee's dependent, as described in paragraph (a) (2), (3), or (4) of this section) not later than 30 days after the exhaustion of the other coverage described in paragraph (a)(5)(ii)(A) of this section or termination of the other coverage as a result of the loss of eligibility for the other coverage for items described in paragraph (a)(5)(ii)(B) of this section or following the termination of employer contributions toward that other coverage. The plan may impose the same requirements that apply to employees who are otherwise eligible under the plan to immediately request enrollment for coverage (e.g., that the request be made in writing).

(7) *Effective date of enrollment.* Enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan that makes coverage available with respect to dependents of a participant is required to provide a special enrollment period to permit individuals described in paragraph (b) (2), (3), (4), (5), or (6) of this section to be enrolled for coverage under the terms of the plan if the enrollment is requested within the time period described in paragraph (b)(7) of this section. The enrollment is effective at the time described in paragraph (b)(8) of this section. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee who is eligible but not enrolled.* An individual is described in this paragraph (b)(2) if the individual is an employee who is eligible, but not enrolled, for coverage under the terms of the plan, the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) *Special enrollment of a spouse of a participant.* An individual is described in this paragraph (b)(3) if either—

(i) The individual becomes the spouse of a participant; or

(ii) The individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption or placement for adoption.

(4) *Special enrollment of an employee who is eligible but not enrolled and the spouse of such employee.* An employee who is eligible, but not enrolled, for coverage under the terms of the plan, and an individual who is a dependent of such employee, are described in this paragraph (b)(4) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either—

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(5) *Special enrollment of a dependent of a participant.* An individual is described in this paragraph (b)(5) if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption or placement for adoption.

(6) *Special enrollment of an employee who is eligible but not enrolled and a new dependent.* An employee who is eligible, but not enrolled, for coverage under the terms of the plan, and an individual who is a dependent of the employee, are described in this paragraph (b)(6) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(7) *Length of special enrollment period.* The special enrollment period under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption (except that such period does not begin earlier than the date the plan makes dependent coverage generally available).

(8) *Effective date of enrollment.* Enrollment is effective—

(i) In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan;

(ii) In the case of a dependent's birth, the date of such birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(9) *Example.* The rules of this paragraph (b) are illustrated by the following example:

Example. (i) Employee *A* is hired on September 3, 1998 by Employer *X*, which has a group health plan in which *A* can elect to enroll either for employee-only coverage, for employee-plus-spouse coverage, or for family coverage, effective on the first day of any calendar quarter thereafter. *A* is married and has no children. *A* does not elect to join Employer *X*'s plan (for employee-only coverage, employee-plus-spouse coverage, or family coverage) on October 1, 1998 or January 1, 1999. On February 15, 1999, a child is placed for adoption with *A* and *A*'s spouse.

(ii) In this *Example,* the conditions for special enrollment of an employee with a new dependent under paragraph (b)(2) of this section are satisfied, the conditions for special enrollment of an employee and a spouse with a new dependent under paragraph (b)(4) of this section are satisfied, and the conditions for special enrollment of an employee and a new dependent under paragraph (b)(6) of this section are satisfied. Accordingly, Employer *X*'s plan will satisfy this paragraph (b) if and only if it allows *A* to elect, by filing the required forms by March 16, 1999, to enroll in Employer *X*'s plan either with employee-only coverage, with employee-plus-spouse coverage, or with family coverage, effective as of February 15, 1999.

(c) *Notice of enrollment rights.* On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under this section. For this purpose, the plan may use the following model description of the special enrollment rules under this section:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(d)(1) *Special enrollment date definition*. A special enrollment date for an individual means any date in paragraph (a)(7) or (b)(8) of this section on which the individual has a right to have enrollment in a group health plan become effective under this section.

(2) *Examples*. The rules of this section are illustrated by the following examples:

Example 1. (i)(A) Employer *Y* maintains a group health plan that allows employees to enroll in the plan either—

(*1*) Effective on the first day of employment by an election filed within three days thereafter;

(*2*) Effective on any subsequent January 1 by an election made during the preceding months of November or December; or

(*3*) Effective as of any special enrollment date described in this section.

(B) Employee *B* is hired by Employer *Y* on March 15, 1998 and does not elect to enroll in Employer *Y*'s plan until January 31, 1999 when *B* loses coverage under another plan. *B* elects to enroll in Employer *Y*'s plan effective on February 1, 1999, by filing the completed request form by January 31, 1999, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 1*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section.

Example 2. (i) Same facts as *Example 1*, except that *B*'s loss of coverage under the other plan occurs on December 31, 1998 and *B* elect to enroll in Employer *Y*'s plan effective on January 1, 1999 by filing the completed request form by December 31, 1998, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 2*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section (even though this date is also a regular enrollment date under the plan).

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§ 2590.701–7 HMO affiliation period as alternative to preexisting condition exclusion.

(a) *In general*. A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the requirements in paragraph (b) of this section is satisfied.

(b) *Requirements for affiliation period*. (1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is applied uniformly without regard to any health status-related factors.

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(c) *Alternatives to affiliation period*. An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Nothing in the part requires a State to receive proposals for or approve alternatives to affiliation periods.

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) *Health factors*. (1) The term *health factor* means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses), as defined in § 2590.701–2;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in § 2590.701–2;

(vii) Evidence of insurability; or

(viii) Disability.

(2) Evidence of insurability includes—

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 2590.701–6, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) *Prohibited discrimination in rules for eligibility*—(1) *In general*—(i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (b)(3) of this section (allowing plans to impose certain preexisting condition exclusions), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to nonconfinement, actively-at-work, and other service requirements), paragraph (f) of this section (relating to bona fide wellness programs), and paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors).

(ii) For purposes of this section, rules for eligibility include, but are not limited to, rules relating to—

(A) Enrollment;

(B) The effective date of coverage;

(C) Waiting (or affiliation) periods;

(D) Late and special enrollment;

(E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

(F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in paragraphs (b)(2) and (3) of this section;

(G) Continued eligibility; and

(H) Terminating coverage (including disenrollment) of any individual under the plan.

(iii) The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, employees who do not enroll within the first 30 days cannot enroll later unless they pass a physical examination.

(ii) *Conclusion.* In this *Example 1*, the requirement to pass a physical examination in order to enroll in the plan is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1).

Example 2. (i) *Facts.* Under an employer's group health plan, employees who enroll during the first 30 days of employment (and during special enrollment periods) may choose between two benefit packages: an indemnity option and an HMO option. However, employees who enroll during late enrollment are permitted to enroll only in the HMO option and only if they provide evidence of good health.

(ii) *Conclusion.* In this *Example 2*, the requirement to provide evidence of good health in order to be eligible for late enrollment in the HMO option is a rule for eligibility that discriminates based on one or more health factors and thus violates this paragraph (b)(1). However, if the plan did not require evidence of good health but limited late enrollees to the HMO option, the plan's rules for eligibility would not discriminate based on any health factor, and thus would not violate this paragraph (b)(1), because the time an individual chooses to enroll is not, itself, within the scope of any health factor.

Example 3. (i) *Facts.* Under an employer's group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) *Conclusion.* In this *Example 3*, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) *Facts.* A group health plan applies for a group health policy offered by an issuer. As part of the application, the issuer receives health information about individuals to be covered under the plan. Individual *A* is an employee of the employer maintaining the plan. *A* and *A*'s dependents have a history of high health claims. Based

on the information about *A* and *A*'s dependents, the issuer excludes *A* and *A*'s dependents from the group policy it offers to the employer.

(ii) *Conclusion*. In this *Example 4*, the issuer's exclusion of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors, and thus violates this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the issuer also may violate 45 CFR 146.150, which requires issuers to offer all the policies they sell in the small group market on a guaranteed available basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for *A* and *A*'s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) *Application to benefits*—(i) *General rule*—(A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan or through group health insurance coverage must be uniformly available to all similarly situated individuals (as described in paragraph (d) of this section). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may impose annual, lifetime, or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance, or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also paragraph (b)(2)(ii) of this section, which permits variances in the application of a cost-sharing mechanism made available under a bona fide wellness program. (Whether any plan provision or practice with respect to benefits complies with this paragraph (b)(2)(i) does not affect whether the provision or practice is permitted under any other provision of the Act, the Americans with Disabilities Act, or any other law, whether State or federal.)

(C) For purposes of this paragraph (b)(2)(i), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(D) The rules of this paragraph (b)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan applies a $500,000 lifetime limit on all benefits to each participant or beneficiary covered under the plan. The limit is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, the limit does not violate this paragraph (b)(2)(i) because $500,000 of benefits are available uniformly to each participant and beneficiary under the plan and because the limit is applied uniformly to all participants and beneficiaries and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts*. A group health plan has a $2 million lifetime limit on all benefits (and no other lifetime limits) for participants covered under the plan. Participant *B* files a claim for the treatment of AIDS. At the next corporate board meeting of the plan sponsor, the claim is discussed. Shortly thereafter, the plan is modified to impose a $10,000 lifetime limit on benefits for the treatment of AIDS, effective before the beginning of the next plan year.

(ii) *Conclusion*. Under the facts of this *Example 2*, the plan violates this paragraph (b)(2)(i) because the plan modification is directed at *B* based on *B*'s claim.

Example 3. (i) A group health plan applies for a group health policy offered by an

issuer. Individual *C* is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about *C*'s adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that *C* has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for *C* for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) *Conclusion*. In this *Example 3*, the issuer violates this paragraph (b)(2)(i) because benefits for *C*'s condition are available to other individuals in the group of similarly situated individuals that includes *C* but are not available to *C*. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates this paragraph (b)(2)(i).

Example 4. (i) *Facts*. A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 4*, the limit does not violate this paragraph (b)(2)(i) because $2000 of benefits for the treatment of TMJ are available uniformly to all similarly situated individuals and a plan may limit benefits covered in relation to a specific disease or condition if the limit applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 5. (i) *Facts*. A group health plan applies a $2 million lifetime limit on all benefits. However, the $2 million lifetime limit is reduced to $10,000 for any participant or beneficiary covered under the plan who has a congenital heart defect.

(ii) *Conclusion*. In this *Example 5*, the lower lifetime limit for participants and beneficiaries with a congenital heart defect violates this paragraph (b)(2)(i) because benefits under the plan are not uniformly available to all similarly situated individuals and the plan's lifetime limit on benefits does not apply uniformly to all similarly situated individuals.

Example 6. (i) *Facts*. A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 6*, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) *Facts*. Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 7*, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) *Cost-sharing mechanisms and wellness programs*. A group health plan or group health insurance coverage with a cost-sharing mechanism (such as a deductible, copayment, or coinsurance) that requires a higher payment from an individual, based on a health factor of that individual or a dependent of that individual, than for a similarly situated individual under the plan (and thus does not apply uniformly to all similarly situated individuals) does not violate the requirements of this paragraph (b)(2) if the payment differential is based on whether an individual has complied with the requirements of a bona fide wellness program.

(iii) *Specific rule relating to source-of-injury exclusions*—(A) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(B) The rules of this paragraph (b)(2)(iii) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan generally provides medical/surgical benefits, including benefits for hospital stays, that are medically necessary. However, the plan

excludes benefits for self-inflicted injuries or injuries sustained in connection with attempted suicide. Individual *D* suffers from depression and attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Pursuant to the exclusion, the plan denies *D* benefits for treatment of the injuries.

(ii) *Conclusion*. In this *Example 1*, the suicide attempt is the result of a medical condition (depression). Accordingly, the denial of benefits for the treatments of *D*'s injuries violates the requirements of this paragraph (b)(2)(iii) because the plan provision excludes benefits for treatment of an injury resulting from a medical condition.

Example 2. (i) *Facts*. A group health plan provides benefits for head injuries generally. The plan also has a general exclusion for any injury sustained while participating in any of a number of recreational activities, including bungee jumping. However, this exclusion does not apply to any injury that results from a medical condition (nor from domestic violence). Participant *E* sustains a head injury while bungee jumping. The injury did not result from a medical condition (nor from domestic violence). Accordingly, the plan denies benefits for *E*'s head injury.

(ii) *Conclusion*. In this *Example 2*, the plan provision that denies benefits based on the source of an injury does not restrict benefits based on an act of domestic violence or any medical condition. Therefore, the provision is permissible under this paragraph (b)(2)(iii) and does not violate this section. (However, if the plan did not allow *E* to enroll in the plan (or applied different rules for eligibility to *E*) because *E* frequently participates in bungee jumping, the plan would violate paragraph (b)(1) of this section.)

(3) *Relationship to § 2590.701–3*. (i) A preexisting condition exclusion is permitted under this section if it —

(A) Complies with § 2590.701–3;

(B) Applies uniformly to all similarly situated individuals (as described in paragraph (d) of this section); and

(C) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this paragraph (b)(3)(i)(C), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

(ii) The rules of this paragraph (b)(3) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan imposes a preexisting condition exclusion on all individuals enrolled in the plan. The exclusion applies to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. In addition, the exclusion generally extends for 12 months after an individual's enrollment date, but this 12-month period is offset by the number of days of an individual's creditable coverage in accordance with § 2590.701–3. There is nothing to indicate that the exclusion is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, even though the plan's preexisting condition exclusion discriminates against individuals based on one or more health factors, the preexisting condition exclusion does not violate this section because it applies uniformly to all similarly situated individuals, is not directed at individual participants or beneficiaries, and complies with § 2590.701–3 (that is, the requirements relating to the six-month look-back period, the 12-month (or 18-month) maximum exclusion period, and the creditable coverage offset).

Example 2. (i) *Facts*. A group health plan excludes coverage for conditions with respect to which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on an individual's enrollment date. Under the plan, the preexisting condition exclusion generally extends for 12 months, offset by creditable coverage. However, if an individual has no claims in the first six months following enrollment, the remainder of the exclusion period is waived.

(ii) *Conclusion*. In this *Example 2*, the plan's preexisting condition exclusions violate this section because they do not meet the requirements of this paragraph (b)(3); specifically, they do not apply uniformly to all similarly situated individuals. The plan provisions do not apply uniformly to all similarly situated individuals because individuals who have medical claims during the first six months following enrollment are not treated the same as similarly situated individuals with no claims during that period. (Under paragraph (d) of this section, the groups cannot be treated as two separate groups of similarly situated individuals because the distinction is based on a health factor.)

(c) Prohibited discrimination in premiums or contributions—(1) *In general*—(i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with

a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) *Rules relating to premium rates*—(i) *Group rating based on health factors not restricted under this section.* Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan.

(ii) *List billing based on a health factor prohibited.* However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) *Examples.* The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual *F* had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of *F*'s claims experience.

(ii) *Conclusion.* In this *Example 1,* the issuer does not violate the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for *F* than for a similarly situated individual based on *F*'s claims experience.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that the issuer quotes the employer a higher premium rate for *F,* because of *F*'s claims experience, than for a similarly situated individual.

(ii) *Conclusion.* In this *Example 2,* the issuer violates this paragraph (c)(2). Moreover, even if the plan purchased the policy based on the quote but did not require a higher participant contribution for *F* than for a similarly situated individual, the issuer would still violate this paragraph (c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for bona fide wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may establish a premium or contribution differential based on whether an individual has complied with the requirements of a bona fide wellness program.

(d) *Similarly situated individuals.* The requirements of this section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) *Participants.* Subject to paragraph (d)(3) of this section, a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee

benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) *Beneficiaries*—(i) Subject to paragraph (d)(3) of this section, a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (e.g., as a spouse or as a dependent child);

(C) Marital status;

(D) With respect to children of a participant, age or student status; or

(E) Any other factor if the factor is not a health factor.

(ii) Paragraph (d)(2)(i) of this section does not prevent more favorable treatment of individuals with adverse health factors in accordance with paragraph (g) of this section.

(3) *Discrimination directed at individuals*. Notwithstanding paragraphs (d)(1) and (2) of this section, if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this paragraph (d), unless it is permitted under paragraph (g) of this section (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this section.

(4) *Examples*. The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan for full-time employees only. Under the plan (consistent with the employer's ususal business practice), employees who normally work at least 30 hours per week are considered to be working full-time. Other employees are considered to be working part-time. There is no evidence to suggest that the classification is directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 1*, treating the full-time and part-time employees as two separate groups of similarly situated individuals is permitted under this paragraph (d) because the classification is bona fide and is not directed at individual participants or beneficiaries.

Example 2. (i) *Facts*. Under a group health plan, coverage is made available to employees, their spouses, and their dependent children. However, coverage is made available to a dependent child only if the dependent child is under age 19 (or under age 25 if the child is continuously enrolled full-time in an institution of higher learning (full-time students)). There is no evidence to suggest that these classifications are directed at individual participants or beneficiaries.

(ii) *Conclusion*. In this *Example 2*, treating spouses and dependent children differently by imposing an age limitation on dependent children, but not on spouses, is permitted under this paragraph (d). Specifically, the distinction between spouses and dependent children is permitted under paragraph (d)(2) of this section and is not prohibited under paragraph (d)(3) of this section because it is not directed at individual participants or beneficiaries. It is also permissible to treat dependent children who are under age 19 (or full-time students under age 25) as a group of similarly situated individuals separate from those who are age 25 or older (or age 19 or older if they are not full-time students) because the classification is permitted under paragraph (d)(2) of this section and is not directed at individual participants or beneficiaries.

Example 3. (i) *Facts*. A university sponsors a group health plan that provides one health benefit package to faculty and another health benefit package to other staff. Faculty and staff are treated differently with respect to other employee benefits such as retirement benefits and leaves of absence. There is no evidence to suggest that the distinction is directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 3,* the classification is permitted under this paragraph (d) because there is a distinction based on a bona fide employment-based classification consistent with the employer's usual business practice and the distinction is not directed at individual participants and beneficiaries.

Example 4. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Former employees may also be eligible, but only if they complete a specified number of years of service, are enrolled under the plan at the time of termination of employment, and are continuously enrolled from that date. There is no evidence to suggest that these distinctions are directed at individual participants or beneficiaries.

(ii) *Conclusion.* In this *Example 4,* imposing additional eligibility requirements on former employees is permitted because a classification that distinguishes between current and former employees is a bona fide employment-based classification that is permitted under this paragraph (d), provided that it is not directed at individual participants or beneficiaries. In addition, it is permissible to distinguish between former employees who satisfy the service requirement and those who do not, provided that the distinction is not directed at individual participants or beneficiaries. (However, former employees who do not satisfy the eligibility criteria may, nonetheless, be eligible for continued coverage pursuant to a COBRA continuation provision or similar State law.)

Example 5. (i) *Facts.* An employer sponsors a group health plan that provides the same benefit package to all seven employees of the employer. Six of the seven employees have the same job title and responsibilities, but Employee *G* has a different job title and different responsibilities. After *G* files an expensive claim for benefits under the plan, coverage under the plan is modified so that employees with *G*'s job title receive a different benefit package that includes a lower lifetime dollar limit than in the benefit package made available to the other six employees.

(ii) *Conclusion.* Under the facts of this *Example 5,* changing the coverage classification for *G* based on the existing employment classification for *G* is not permitted under this paragraph (d) because the creation of the new coverage classification for *G* is directed at *G* based on one or more health factors.

(e) *Nonconfinement and actively-at-work provisions*—(1) *Nonconfinement provisions*—(i) *General rule.* Under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) *Examples.* The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) *Facts.* In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer *M.* However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer *N.* Under Issuer *N*'s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) *Conclusion.* In this *Example 2,* Issuer *N* violates this paragraph (e)(1) because the group health insurance coverage restricts benefits (a rule for eligibility under paragraph (b)(1)) based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits clause from a previous issuer. This section does not affect any obligation Issuer M may have under applicable State law to provide any extension of benefits and does not affect any State law governing coordination of benefits.

(2) *Actively-at-work and continuous service provisions*—(i) *General rule*—(A) Under the rules of paragraphs (b) and

(c) of this section and subject to the exception for the first day of work described in paragraph (e)(2)(ii) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) *Conclusion.* In this *Example 1,* the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) *Facts.* Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) *Conclusion.* In this *Example 2,* the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service.

(ii) *Exception for the first day of work*—(A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual *H* is scheduled to begin work on August 3. However, *H* is unable to begin work on that day because of illness. *H* begins working on August 4, and *H*'s coverage is effective on August 4.

(ii) *Conclusion.* In this *Example 1,* the plan provision does not violate this section. However, if coverage for individuals who do not report to work on the first day they were scheduled to work for a reason unrelated to a health factor (such as vacation or bereavement) becomes effective on the first day they were scheduled to work, then the plan would violate this section.

Example 2. (i) *Facts.* Under a group health plan, coverage for new employees becomes effective on the first day of the month following the employee's first day of work, regardless of whether the employee is actively at work on the first day of the month. Individual *J* is scheduled to begin work on March 24. However, *J* is unable to begin work on March 24 because of illness. *J* begins working on April 7 and *J*'s coverage is effective May 1.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section. However, as in *Example 1,* if coverage for individuals absent from work for reasons unrelated to a health factor became effective despite their absence, then the plan would violate this section.

(3) *Relationship to plan provisions defining similarly situated individuals*—(i) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a plan or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for

the employer, subject to paragraph (d) of this section. However, other federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section.

(ii) *Conclusion.* In this *Example 1,* the plan provisions do not violate this section. However, if the plan treated individuals performing services for the employer for 30 or more hours per week, individuals on vacation leave, and individuals on bereavement leave as a group of similarly situated individuals separate from individuals on sick leave, the plan would violate this paragraph (e) (and thus also would violate paragraph (b) of this section) because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) *Facts.* To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) *Conclusion.* In this *Example 2,* the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee *B* has been covered under the plan. *B* experiences a disabling illness that prevents *B* from working. *B* takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, *B* terminates employment and consequently loses coverage under the plan. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 3,* the plan provision terminating *B*'s coverage upon *B*'s termination of employment does not violate this section.

Example 4. (i) *Facts.* Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee *C* is laid off for three months. When the layoff begins, *C*'s coverage under the plan is terminated. (This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 4,* the plan provision terminating *C*'s coverage upon the cessation of *C*'s performance of services does not violate this section.

(f) *Bona fide wellness programs.* [Reserved.]

(g) *More favorable treatment of individuals with adverse health factors permitted*—(1) *In rules for eligibility*—(i) Nothing in this section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit premium rates; these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 23. However, dependent children who are disabled are eligible for coverage beyond age 23.

(ii) *Conclusion.* In this *Example 1*, the plan provision allowing coverage for disabled dependent children beyond age 23 satisfies this paragraph (g)(1) (and thus does not violate this section).

Example 2. (i) *Facts.* An employer sponsors a group health plan, which is generally available to employees (and members of the employee's family) until the last day of the month in which the employee ceases to perform services for the employer. The plan generally charges employees $50 per month for employee-only coverage and $125 per month for family coverage. However, an employee who ceases to perform services for the employer by reason of disability may remain covered under the plan until the last day of the month that is 12 months after the month in which the employee ceased to perform services for the employer. During this extended period of coverage, the plan charges the employee $100 per month for employee-only coverage and $250 per month for family coverage. (This extended period of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.)

(ii) *Conclusion.* In this *Example 2*, the plan provision allowing extended coverage for disabled employees and their families satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled employees a higher premium during the extended period of coverage.

Example 3. (i) *Facts.* To comply with the requirements of a COBRA continuation provision, a group health plan generally makes COBRA continuation coverage available for a maximum period of 18 months in connection with a termination of employment but makes the coverage available for a maximum period of 29 months to certain disabled individuals and certain members of the disabled individual's family. Although the plan generally requires payment of 102 percent of the applicable premium for the first 18 months of COBRA continuation coverage, the plan requires payment of 150 percent of the applicable premium for the disabled individual's COBRA continuation coverage during the disability extension if the disabled individual would not be entitled to COBRA continuation coverage but for the disability.

(ii) *Conclusion.* In this *Example 3,* the plan provision allowing extended COBRA continuation coverage for disabled individuals satisfies this paragraph (g)(1) (and thus does not violate this section). In addition, the plan is permitted, under this paragraph (g)(1), to charge the disabled individuals a higher premium for the extended coverage if the individuals would not be eligible for COBRA continuation coverage were it not for the disability. (Similarly, if the plan provided an extended period of coverage for disabled individuals pursuant to State law or plan provision rather than pursuant to a COBRA continuation coverage provision, the plan could likewise charge the disabled individuals a higher premium for the extended coverage.)

(2) *In premiums or contributions*—(i) Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

(ii) The rules of this paragraph (g)(2) are illustrated by the following example:

Example. (i) *Facts.* Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) *Conclusion.* In this *Example,* the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) *No effect on other laws.* Compliance with this section is not determinative of compliance with any other provision of the Act (including the COBRA continuation provisions) or any other State or federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans and issuers, this section does not affect any

other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates*—(1) *Paragraphs applicable May 8, 2001.* Paragraphs (a)(1), (a)(2)(i), (b)(1)(i), (b)(1)(iii) *Example 1*, (b)(2)(i)(A), (b)(2)(ii), (c)(1)(i), (c)(2)(i), and (c)(3) of this section and this paragraph (*i*)(1) apply to group health plans and health insurance issuers offering group health insurance coverage May 8, 2001.

(2) *Paragraphs applicable for plan years beginning on or after July 1, 2001.* Except as provided in paragraph (*i*)(3) of this section, the provisions of this section not listed in paragraph (*i*)(1) of this section apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2001. Except as provided in paragraph (*i*)(3) of this section, with respect to efforts to comply with section 702 of the Act before the first plan year beginning on or after July 1, 2001, the Secretary will not take any enforcement action against a plan that has sought to comply in good faith with section 702 of the Act.

(3) *Transitional rules for individuals previously denied coverage based on a health factor.* This paragraph (*i*)(3) provides rules relating to individuals previously denied coverage under a group health plan or group health insurance coverage based on a health factor of the individual. Paragraph (*i*)(3)(i) clarifies what constitutes a denial of coverage under this paragraph (*i*)(3). Paragraph (*i*)(3)(ii) of this section applies with respect to any individual who was denied coverage if the denial was not based on a good faith interpretation of section 702 of the Act or the Secretary's published guidance. Under that paragraph, such an individual must be allowed to enroll retroactively to the effective date of section 702 of the Act, or, if later, the date the individual meets eligibility criteria under the plan that do not discriminate based on any health factor. Paragraph (*i*)(3)(iii) of this section applies with respect to any individual who was denied coverage based on a good faith interpretation of section 702 of the Act or the Secretary's published guidance. Under that paragraph, such an individual must be given an opportunity to enroll effective July 1, 2001. In either event, whether under paragraph (i)(3)(ii) or (iii) of this section, the Secretary will not take any enforcement action with respect to denials of coverage addressed in this paragraph (i)(3) if the plan has complied with the transitional rules of this paragraph (i)(3).

(i) *Denial of coverage clarified.* For purposes of this paragraph (i)(3), an individual is considered to have been denied coverage if the individual—

(A) Failed to apply for coverage because it was reasonable to believe that an application for coverage would have been futile due to a plan provision that discriminated based on a health factor; or

(B) Was not offered an opportunity to enroll in the plan and the failure to give such an opportunity violates this section.

(ii) *Individuals denied coverage without a good faith interpretation of the law*—(A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual based on a health factor and that denial was not based on a good faith interpretation of section 702 of the Act or any guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days. This opportunity must be presented not later than May 8, 2001.

(*1*) If this enrollment opportunity was presented before or within the first plan year beginning on or after July 1, 1997 (or in the case of a collectively bargained plan, before or within the first plan year beginning on the effective date for the plan described in section 101(g)(3) of the Health Insurance Portability and Accountability Act of 1996), the coverage must be effective within that first plan year.

(*2*) If this enrollment opportunity is presented after such plan year, the individual must be given the choice of having the coverage effective on either of the following two dates—

(*i*) The date the plan receives a request for enrollment in connection with the enrollment opportunity; or

(*ii*) Retroactively to the first day of the first plan year beginning on the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act of 1996 (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). If an individual elects retroactive coverage, the plan or issuer is required to provide the benefits it would have provided if the individual had been enrolled for coverage during that period (irrespective of any otherwise applicable plan provisions governing timing for the submission of claims). The plan or issuer may require the individual to pay whatever additional amount the individual would have been required to pay for the coverage (but the plan or issuer cannot charge interest on that amount).

(B) *Relation to preexisting condition rules.* For purposes of part 7 of subtitle B of title I of the Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan), even if the individual chooses under paragraph (i)(3)(ii)(A) of this section to have coverage effective only prospectively. In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Examples.* The rules of this paragraph (i)(3)(ii) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *X* maintains a group health plan with a plan year beginning October 1 and ending September 30. Individual *F* was hired by Employer *X* before the effective date of section 702 of the Act. Before the effective date of section 702 of the Act for this plan (October 1, 1997), the terms of the plan allowed employees and their dependents to enroll when the employee was first hired, and on each January 1 thereafter, but in either case, only if the individual could pass a physical examination. *F*'s application to enroll when first hired was denied because *F* had diabetes and could not pass a physical examination. Upon the effective date of section 702 of the Act for this plan (October 1, 1997), the plan is amended to delete the requirement to pass a physical examination. In November of 1997, the plan gives *F* an opportunity to enroll in the plan (including notice of the opportunity to enroll) without passing a physical examination, with coverage effective January 1, 1998.

(ii) *Conclusion.* In this *Example 1,* the plan complies with the requirements of this paragraph (*i*)(3)(ii).

Example 2. (i) *Facts.* The plan year of a group health plan begins January 1 and ends December 31. Under the plan, a dependent who is unable to engage in normal life activities on the date coverage would otherwise become effective is not enrolled until the dependent is able to engage in normal life activities. Individual *G* is a dependent who is otherwise eligible for coverage, but is unable to engage in normal life activities. The plan has not allowed *G* to enroll for coverage.

(ii) *Conclusion.* In this *Example 2,* beginning on the effective date of section 702 of the Act for the plan (January 1, 1998), the plan provision is not permitted under any good faith interpretation of section 702 of the Act or any guidance published by the Secretary. Therefore, the plan is required, not later than May 8, 2001, to give *G* an opportunity to enroll (including notice of the opportunity to enroll), with coverage effective, at *G*'s option, either retroactively from January 1, 1998 or prospectively from the date *G*'s request for enrollment is received by the plan. If *G* elects coverage to be effective beginning January 1, 1998, the plan can require G to pay any required employee premiums for the retroactive coverage.

(iii) *Individuals denied coverage based on a good faith interpretation of the law*—(A) *Opportunity to enroll required.* If a plan or issuer has denied coverage to any individual before the first day of the first plan year beginning on or after July 1, 2001 based in part on a health factor and that denial was based on a good faith interpretation of section 702 of the Act or guidance published by the Secretary, the plan or issuer is required to give the individual an opportunity to enroll (including notice of an opportunity to enroll) that continues for at least 30 days, with coverage effective no later than July 1, 2001. Individuals required to be offered an opportunity to enroll include individuals previously offered enrollment without regard to a health factor but subsequently denied enrollment due to a health factor.

(B) *Relation to preexisting condition rules*. For purposes of Part 7 of Subtitle B of Title I of the Act, the individual may not be treated as a late enrollee or as a special enrollee. Moreover, the individual's enrollment date is the effective date for the plan described in sections 101(g)(1) and (3) of the Health Insurance Portability and Accountability Act (or, if the individual otherwise first became eligible to enroll for coverage after that date, on the date the individual was otherwise eligible to enroll in the plan). In addition, any period between the individual's enrollment date and the effective date of coverage is treated as a waiting period.

(C) *Example*. The rules of this paragraph (*i*)(3)(iii) are illustrated by the following example:

Example. (i) *Facts*. Individual *H* was hired by Employer *Y* on May 3, 1995. *Y* maintains a group health plan with a plan year beginning on February 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired (without a requirement to pass a physical examination), and on each February 1 thereafter if the individual can pass a physical examination. *H* chose not to enroll for coverage when hired in May of 1995. On February 1, 1997, *H* tried to enroll for coverage under the plan. However, *H* was denied coverage for failure to pass a physical examination. Shortly thereafter, *Y*'s plan eliminated late enrollment, and *H* was not given another opportunity to enroll in the plan. There is no evidence to suggest that *Y*'s plan was acting in bad faith in denying coverage under the plan beginning on the effective date of section 702 of the Act (February 1, 1998).

(ii) *Conclusion*. In this *Example*, because coverage previously had been made available with respect to *H* without regard to any health factor of *H* and because *Y*'s plan was acting in accordance with a good faith interpretation of section 702 (and guidance published by the Secretary), the failure of *Y*'s plan to allow *H* to enroll effective February 1, 1998 was permissible on that date. However, under the transitional rules of this paragraph (*i*)(3)(iii), *Y*'s plan must give *H* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (In addition, February 1, 1998 is *H*'s enrollment date under the plan and the period between February 1, 1998 and July 1, 2001 is treated as a waiting period. Accordingly, any preexisting condition exclusion period permitted under § 2590.701–3 will have expired before July 1, 2001.)

[66 FR 1404, Jan. 8, 2001, as amended at 66 FR 14077, Mar. 9, 2001]

§ 2590.703 Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements. [Reserved]

Subpart C—Other Requirements

SOURCE: 62 FR 16941, Apr. 8, 1997. Redesignated at 65 FR 62142, Dec. 27, 2000, unless otherwise noted.

§ 2590.711 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule*. Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital*. If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital*. If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples*. The rules of paragraphs (a)(1) and (2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on

June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this *Example 2*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this *Example 3*, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) *Authorization not required*—(i) *In general.* A plan or issuer may not require that a physician or other health care provider obtain authorization from the plan or issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (*See also* paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) *Example.* The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by caesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this *Example*, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by caesarean section is prohibited by this paragraph (a)(4).

(5) *Exceptions*—(i) *Discharge of mother.* If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(ii) *Discharge of newborn.* If a decision to discharge a newborn child earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother (or the newborn's authorized representative), the requirements of paragraph (a)(1) of this section do not apply for any period after the discharge.

(iii) *Attending provider defined.* For purposes of this section, *attending provider* means an individual who is licensed under applicable State law to provide maternity or pediatric care and who is directly responsible for providing maternity or pediatric care to a mother or newborn child.

(iv) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A pregnant woman covered under a group health plan subject to the requirements of this section goes into labor and is admitted to a hospital. She gives birth by caesarean section. On the third day after the delivery, the attending provider for the mother consults with the mother, and the attending provider for the newborn consults with the mother regarding the newborn. The attending providers authorize the early discharge of both the mother and the newborn. Both are discharged approximately 72 hours after the delivery. The plan pays for the 72-hour hospital stays.

(ii) In this *Example*, the requirements of this paragraph (a) have been satisfied with respect to the mother and the newborn. If either is readmitted, the hospital stay for the readmission is not subject to this section.

(b) *Prohibitions*—(1) *With respect to mothers*—(i) *In general.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not—

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.

(ii) *Examples*. The rules of this paragraph (b)(1) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. If a mother and newborn covered under the plan are discharged within 24 hours after the delivery, the plan will waive the copayment and deductible.

(ii) In this *Example 1*, because waiver of the copayment and deductible is in the nature of a rebate that the mother would not receive if she and her newborn remained in the hospital, it is prohibited by this paragraph (b)(1). (In addition, the plan violates paragraph (b)(2) of this section because, in effect, no copayment or deductible is required for the first portion of the stay and a double copayment and a deductible are required for the second portion of the stay.)

Example 2. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay following a vaginal delivery. In the event that a mother and her newborn are discharged earlier than 48 hours and the discharges occur after consultation with the mother in accordance with the requirements of paragraph (a)(5) of this section, the plan provides for a follow-up visit by a nurse within 48 hours after the discharges to provide certain services that the mother and her newborn would otherwise receive in the hospital.

(ii) In this *Example 2*, because the follow-up visit does not provide any services beyond what the mother and her newborn would receive in the hospital, coverage for the follow-up visit is not prohibited by this paragraph (b)(1).

(2) *With respect to benefit restrictions*—(i) *In general*. Subject to paragraph (c)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not restrict the benefits for any portion of a hospital length of stay required under paragraph (a) of this section in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

(ii) *Example*. The rules of this paragraph (b)(2) are illustrated by the following example:

Example. (i) A group health plan subject to the requirements of this section provides benefits for hospital lengths of stay in connection with childbirth. In the case of a delivery by caesarean section, the plan automatically pays for the first 48 hours. With respect to each succeeding 24-hour period, the participant or beneficiary must call the plan to obtain precertification from a utilization reviewer, who determines if an additional 24-hour period is medically necessary. If this approval is not obtained, the plan will not provide benefits for any succeeding 24-hour period.

(ii) In this *Example*, the requirement to obtain precertification for the two 24-hour periods immediately following the initial 48-hour stay is prohibited by this paragraph (b)(2) because benefits for the latter part of the stay are restricted in a manner that is less favorable than benefits for a preceding portion of the stay. (However, this section does not prohibit a plan from requiring precertification for any period after the first 96 hours.) In addition, if the plan's utilization reviewer denied any mother or her newborn benefits within the 96-hour stay, the plan would also violate paragraph (a) of this section.

(3) *With respect to attending providers*. A group health plan, and a health insurance issuer offering group health insurance coverage, may not directly or indirectly—

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) *Construction*. With respect to this section, the following rules of construction apply:

(1) *Hospital stays not mandatory*. This section does not require a mother to—

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) *Hospital stay benefits not mandated*. This section does not apply to any group health plan, or any group health insurance coverage, that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

(3) *Cost-sharing rules*—(i) *In general*. This section does not prevent a group

health plan or a health insurance issuer offering group health insurance coverage from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay required under paragraph (a) of this section may not be greater than that for any preceding portion of the stay.

(ii) *Examples*. The rules of this paragraph (c)(3) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section, as follows:

Example 1. (i) A group health plan provides benefits for at least a 48-hour hospital length of stay in connection with vaginal deliveries. The plan covers 80 percent of the cost of the stay for the first 24-hour period and 50 percent of the cost of the stay for the second 24-hour period. Thus, the coinsurance paid by the patient increases from 20 percent to 50 percent after 24 hours.

(ii) In this *Example 1*, the plan violates the rules of this paragraph (c)(3) because coinsurance for the second 24-hour period of the 48-hour stay is greater than that for the preceding portion of the stay. (In addition, the plan also violates the similar rule in paragraph (b)(2) of this section.)

Example 2. (i) A group health plan generally covers 70 percent of the cost of a hospital length of stay in connection with childbirth. However, the plan will cover 80 percent of the cost of the stay if the participant or beneficiary notifies the plan of the pregnancy in advance of admission and uses whatever hospital the plan may designate.

(ii) In this *Example 2*, the plan does not violate the rules of this paragraph (c)(3) because the level of benefits provided (70 percent or 80 percent) is consistent throughout the 48-hour (or 96-hour) hospital length of stay required under paragraph (a) of this section. (In addition, the plan does not violate the rules in paragraph (a)(4) or (b)(2) of this section.)

(4) *Compensation of attending provider*. This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) *Notice requirement*. See 29 CFR 2520.102–3 (u) and (v)(2) (relating to the disclosure requirement under section 711(d) of the Act).

(e) *Applicability in certain States*—(1) *Health insurance coverage*. The requirements of section 711 of the Act and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a State law regulating the coverage that meets any of the following criteria:

(i) The State law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by caesarean section.

(ii) The State law requires the coverage to provide for maternity and pediatric care in accordance with guidelines established by the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, or any other established professional medical association.

(iii) The State law requires, in connection with the coverage for maternity care, that the hospital length of stay for such care is left to the decision of (or is required to be made by) the attending provider in consultation with the mother. State laws that require the decision to be made by the attending provider with the consent of the mother satisfy the criterion of this paragraph (e)(1)(iii).

(2) *Group health plans*—(i) *Fully-insured plans*. For a group health plan that provides benefits solely through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section do not apply.

(ii) *Self-insured plans*. For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 711 of the Act and this section apply.

(iii) *Partially-insured plans*. For a group health plan that provides some benefits through health insurance coverage, if the State law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this

section, then the requirements of section 711 of the Act and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) *Relation to section 731(a) of the Act.* The preemption provisions contained in section 731(a)(1) of the Act and § 2590.731(a) do not supersede a State law described in paragraph (e)(1) of this section.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) A group health plan buys group health insurance coverage in a State that requires that the coverage provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by caesarean section.

(ii) In this *Example 1,* the coverage is subject to State law, and the requirements of section 711 of the Act and this section do not apply.

Example 2. (i) A self-insured group health plan covers hospital lengths of stay in connection with childbirth in a State that requires health insurance coverage to provide for maternity care in accordance with guidelines established by the American College of Obstetricians and Gynecologists and to provide for pediatric care in accordance with guidelines established by the American Academy of Pediatrics.

(ii) In this *Example 2,* even though the State law satisfies the criterion of paragraph (e)(1)(ii) of this section, because the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the plan is subject to the requirements of section 711 of the Act and this section.

(f) *Effective date.* Section 711 of the Act applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1998. This section applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 1999.

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§ 2590.712 Parity in the application of certain limits to mental health benefits.

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

Aggregate lifetime limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Annual limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

Mental health benefits means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits*—(1)—*general*—(i) *General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any

medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

Example 1. (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a $10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a $500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 2. (i) Prior to the effective date of the mental health parity provisions, a group health plan had a $100,000 annual limit on medical/surgical inpatient benefits, a $50,000 annual limit on medical/surgical outpatient benefits, and a $100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a $150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a $100,000 annual limit on mental health inpatient benefits and a $50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 3. (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

Example 4. (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits

and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section*—(i) *In general.* A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) A group health plan that is subject to the requirements of this section includes a $100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit

that can be applied to mental health benefits is $640,000 (40% x $100,000 + 60% x $1,000,000 = $640,000).

(c) *Rule in the case of separate benefit packages*. If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability*—(1) *Group health plans*. The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers*. The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope*. This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption*—(1) *In general*. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and § 2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size*. For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption*—(1) *In general*. A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements

in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase*—(i) *Ratio*. A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(*1*) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(*2*) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula*. The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE-(CE+AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures*. *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period*. *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104–204, 110 Stat. 2944)).

(v) *Rating pools*. For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples*. The rules of this paragraph (f)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998.

On September 15, 1998, the plan determines that $1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that $100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are $1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are $40,000 and that administrative expenses attributable to complying with the requirements of this section are $10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $1,050,000 ($1,100,000 − ($40,000 + $10,000) = $1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ($1,100,000/$1,050,000 = 1.04762).

Example 2. (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

Example 3. (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be $2,000,000 and the administrative expenses for the base period for the self-funded portion to be $200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are $1,000,000 and the administrative expenses for the base period are $100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are $1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are $25,000 and the administrative costs attributable to complying with the requirements of this section are $1,000. Thus, the total incurred expenditures for the plan for the base period are $3,300,000 ($2,000,000 + $200,000 + $1,000,000 + $100,000 = $3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are $3,273,000 ($3,300,000 − ($0 + $1,000 + $25,000 + $1,000) = $3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ($3,300,000/$3,273,000 = 1.00825).

(3) *Notice of exemption*—(i) *Participants and beneficiaries*—(A) *In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(*1*) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(*2*) The name and telephone number of the individual to contact for further information;

(*3*) The plan name and plan number (PN);

(*4*) The plan administrator's name, address, and telephone number;

(*5*) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(*3*) of this section) and the plan sponsor's employer identification number (EIN);

(*6*) The effective date of the exemption;

(*7*) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(*8*) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under § 2520.104b–3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery*. The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example*. The rules of this paragraph (f)(3)(i) are illustrated by the following example:

Example. (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example,* the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies*—(A) *Church plans*. A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA*. A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) *Nonfederal governmental plans*. A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation*. The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with

paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage*—(1) *Sale of nonparity policies.* An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates*—(1) *In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

Example 1. (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

Example 2. (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a $1,000,000 annual limit on medical/surgical benefits and a $100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption*—(i) *In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b–1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(*1*) The name of the plan and the plan number (PN);

(*2*) The name, address, and telephone number of the plan administrator;

(*3*) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(*4*) The name and telephone number of the individual to contact for further information; and

(*5*) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset*. This section does not apply to benefits for services furnished on or after September 30, 2001.

[62 FR 66957, Dec. 22, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000]

Subpart D—General Provisions

SOURCE: 62 FR 16941, Apr. 8, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000, unless otherwise noted.

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers*. Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part 7 of subtitle B of title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirements of this part.

(b) *Continued preemption with respect to group health plans*. Nothing in part 7 of subtitle B of title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general*. Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions*. Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 701(a)(1) of the Act and § 2590.701–3(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 701(a)(2) of the Act and § 2590.701–3(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63 day period'' described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701–3(a)(1)(iii) and 2590.701–4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 701 (b)(2) and (d)(1) of the Act and § 2590.701–3(b) (for purposes of the enrollment periods and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law*. For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a

State law rather than a law of the United States.

(2) *State*. For purposes of this section the term *State* includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Island, or any agency or instrumentality of either.

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, 31693, June 10, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000]

§ 2590.732 Special rules relating to group health plans.

(a) *General exception for certain small group health plans*. The requirements of this part 7 of subtitle B of title I of the Act do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general*. The requirements of subparts A and C of this part do not apply to any group health plan (or any group health insurance coverage offered in connection with a group health plan) in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances*. The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general*. Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral*. For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope*. Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care*. Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated*. Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions*. Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to

the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under chapter 55, title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

[62 FR 16941, Apr. 8, 1997; 62 FR 31670, June 10, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000]

§ 2590.734 Enforcement. [Reserved]

§ 2590.736 Applicability dates.

(a) *General applicability dates*—(1) *Non-collectively bargained plans.* Part 7 of Subtitle B of Title I of the Act and §§ 2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans.* Except as otherwise provided in this section (other than in paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part 7 of Subtitle B of Title I of the Act and §§ 2590.701–1 through 2590.701–7, 2590.703, 2590.731 through 2590.734, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under § 2590.701–3 is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under § 2590.701–3, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part 7 of subtitle B of title I of the Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation of § 2590.701–3. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

Example 1. (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997 and *A* has no creditable coverage before this date.

(ii) In this *Example 1,* Employer *X* may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2. (i) Same facts as in *Example 1,* except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2,* on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have; however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of *A* received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *In general.* Subject to the transitional rule in § 2590.701–5(a)(5)(iii), the certification rules of § 2590.701–5 apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of subpart A or C of this part, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, pursuant to part 7 of subtitle B of title I of the Act, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by part 7 of subtitle B of title I of the Act before January 1, 1998, if the plan or issuer has sought to comply in good faith with such requirements. Compliance with this part is deemed to be good faith compliance with the requirements of part 7 of subtitle B of title I of the Act.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of § 2590.701–5(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer are not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under § 2590.701–5(c).

(e) *Transition rules for certificates of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996, but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under § 2590.701–5(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *In general.* This paragraph (e)(3) applies with respect to events described in § 2590.701–5(a)(2)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy § 2590.701–5(a) (2) and (3) if a notice is provided in accordance with the provisions of paragraphs (e)(3) (i) through (iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided pursuant to this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretary. Copies of the model notice are available on the following website—http://www.dol.gov/dol/pwba/ (or call 1–800–998–7542).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in § 2590.701–5(a)(2)(iii).

(v) *Other certification rules apply.* The rules set forth in § 2590.701–5(a)(4)(i) (method of delivery) and § 2590.701–5(a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

[62 FR 16941, Apr. 8, 1997; 62 FR 31693, June 10, 1997. Redesignated at 65 FR 82142, Dec. 27, 2000; 66 FR 1411, Jan. 8, 2001]