when a tax return preparer who prepared a return or claim for refund for tax under chapter 43 of subtitle D of the Internal Revenue Code pays 15 percent of a penalty for understatement of taxpayer's liability, and procedural matters relating to the investigation, assessment and collection of the penalties under section 6694(a) and (b), the rules under §1.6694–4 of this chapter will apply.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78459, Dec. 22, 2008]

### §54.6695–1 Other assessable penalties with respect to the preparation of tax returns for other persons.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under chapter 43 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties for failure to furnish a copy to the taxpayer under section 6695(a) of the Code, failure to sign the return under section 6695(b) of the Code, failure to furnish an identification number under section 6695(c) of the Code, failure to retain a copy or list under section 6695(d) of the Code, failure to file a correct information return under section 6695(e) of the Code, and negotiation of a check under section 6695(f) of the Code, in the manner stated in §1.6695–1 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed after December 31, 2008.

[T.D. 9436, 73 FR 78459, Dec. 22, 2008]

### §54.6696–1 Claims for credit or refund by tax return preparers.

(a) *In general.* For rules for claims for credit or refund by a tax return preparer who prepared a return or claim for refund for excise tax under chapter 43 of subtitle D of the Internal Revenue Code, the rules under §1.6696–1 of this chapter will apply.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78459, Dec. 22, 2008]

### §54.7701–1 Tax return preparer.

(a) *In general.* For the definition of a tax return preparer, see §301.7701–15 of this chapter.

(b) *Effective/applicability date.* This section is applicable to returns and claims for refund filed, and advice provided, after December 31, 2008.

[T.D. 9436, 73 FR 78459, Dec. 22, 2008]

### §54.9801–1 Basis and scope.

(a) *Statutory basis.* This section and sections 54.9801–2 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9802–3T, 54.9811–1, 54.9812–1T, 54.9831–1, and 54.9833–1 (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(5) Prohibition against discrimination on the basis of health factors.

(6) Additional requirements prohibiting discrimination based on genetic information.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act.* Sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 29 CFR part 2590 and 45 CFR parts 144, 146, and 148. See also part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in

the individual market (defined in § 54.9801–2).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9299, 71 FR 75056, Dec. 13, 2006; T.D. 9427, 73 FR 62419, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009]

### § 54.9801–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of § 54.9801–1, this section, §§ 54.9801–3 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9802–3T, 54.9811–1, 54.9812–1T, 54.9831–1, and 54.9833–1.

*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 section 4980B (other than paragraph (f)(1) of section 4980B insofar as it relates to pediatric vaccines), sections 601–608 of ERISA, or Title XXII of the PHS Act.

(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;

(ii) When the individual no longer resides, lives, or works in the 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; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits 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 § 54.9801–4(a).

*Dependent* means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

*Employee Retirement Income Security Act of 1974 (ERISA)* means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

*Enroll* means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health 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*, *first day of coverage*, and *waiting period*) are set forth in § 54.9801–3(a)(3)(i), (ii), and (iii).

*Excepted benefits* means the benefits described as excepted in § 54.9831(c).

*Genetic information* has the meaning given the term in § 54.9802–3T(a)(3).

*Group health insurance coverage* means health insurance coverage offered in connection with a group health plan.

*Group health plan* or *plan* means a *group health plan* within the meaning of § 54.9831(a).

*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