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§ 53.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of tax under Chapter 42 of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 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 78457, Dec. 22, 2008]

§ 53.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

(a) *In general.* For rules relating to the extension of period of collection when a tax return preparer who prepared a return or claim for refund of tax under Chapter 42 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 78458, Dec. 22, 2008]

§ 53.6695–1 Other assessable penalties with respect to the preparation of tax returns or claims for refund 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 42 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 78458, Dec. 22, 2008]

§ 53.6696–1 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 tax under Chapter 42 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 78458, Dec. 22, 2008]

§ 53.7101–1 Form of bonds.

For provisions relating to form of bonds, see the regulations under section 7101 contained in part 301 of this chapter (Regulations on Procedure and Administration).

§ 53.7701–1 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 78458, Dec. 22, 2008]

PART 54—PENSION EXCISE TAXES

Sec.

54.4971–1 General rules relating to excise tax on failure to meet minimum funding standards.
54.4972–1 Tax on excess contributions to plans benefiting self-employed individuals.
54.4974–1 Excise tax on accumulations in individual retirement accounts or annuities.
54.4974–2 Excise tax on accumulations in qualified retirement plans.
54.4975–1 General rules relating to excise tax on prohibited transactions.
54.4975–6 Statutory exemptions for office space or services and certain transactions involving financial institutions.

54.4975–7 Other statutory exemptions.
54.4975–9 Definition of ''fiduciary''.
54.4975–11 ''ESOP'' requirements.
54.4975–12 Definition of the term ''qualifying employer security''.
54.4975–14 Election to pay an excise tax for certain pre-1975 prohibited transactions.
54.4975–15 Other transitional rules.
54.4976–1T Questions and answers relating to taxes with respect to welfare benefit funds (temporary).
54.4977–1T Questions and answers relating to the election concerning lines of business in existence on January 1, 1984 (temporary).
54.4978–1T Questions and answers relating to the tax on certain dispositions by employee stock ownership plans and certain cooperatives (temporary).
54.4979–0 Excise tax on certain excess contributions and excess aggregate contributions; table of contents.
54.4979–1 Excise tax on certain excess contributions and excess aggregate contributions.
54.4980B–0 Table of contents.
54.4980B–1 CORBA in general.
54.4980B–2 Plans that must comply.
54.4980B–3 Qualified beneficiaries.
54.4980B–4 Qualifying events.
54.4980B–5 CORBA continuation coverage.
54.4980B–6 Electing COBRA continuation coverage.
54.4980B–7 Duration of CORBA continuation coverage.
54.4980B–8 Paying for COBRA continuation coverage.
54.4980B–9 Business reorganizations and employer withdrawals from multiemployer plans.
54.4980B–10 Interaction of FMLA and COBRA.
54.4980D–1 Requirement of return and time for filing of the excise tax under section 4980D.
54.4980E–1 Requirement of return and time for filing of the excise tax under section 4980E.
54.4980F–1 Notice requirements for certain pension plan amendments significantly reducing the rate of future benefit accrual.
54.4980G–0 Table of contents.
54.4980G–1 Failure of employer to make comparable health savings account contributions.
54.4980G–2 Employer contribution defined.
54.4980G–3 Failure of employer to make comparable health savings account contributions.
54.4980G–4 Calculating comparable contributions.
54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.
54.4980G–6 Special rule for contributions made to the HSAs of nonhighly compensated employees.
54.4980G–7 Special comparability rules for qualified HSA distributions contributed to HSAs on or after December 20, 2006 and before January 1, 2012.
54.4981A–1T Tax on excess distributions and excess accumulations (temporary).
54.6011–1 General requirement of return, statement, or list.
54.6011–1T General requirement of return, statement, or list (temporary).
54.6011–2 General requirement of return, statement, or list.
54.6011–4 Requirement of statement disclosing participation in certain transactions by taxpayers.
54.6060–1 Reporting requirements for tax return preparers.
54.6061–1 Signing of returns and other documents.
54.6071–1 Time for filing returns.
54.6081–1 Automatic extension of time for filing returns for certain excise taxes under Chapter 43.
54.6091–1 Place for filing excise tax returns under section 4980B, 4980D, 4980E, or 4980G.
54.6107–1 Tax return preparer must furnish copy of return or claims for refund to taxpayer and must retain a copy or record.
54.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund filed.
54.6151–1 Time and place for paying of tax shown on returns.
54.6694–1 Section 6694 penalties applicable to tax return preparer.
54.6694–2 Penalties for understatement due to an unreasonable position.
54.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.
54.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.
54.6695–1 Other assessable penalties with respect to the preparation of tax returns for other persons.
54.6696–1 Claims for credit or refund by tax return preparers.
54.7701–1 Tax return preparer.
54.9801–1 Basis and scope.
54.9801–2 Definitions.
54.9801–3 Limitations on preexisting condition exclusion period.
54.9801–4 Rules relating to creditable coverage.
54.9801–5 Evidence of creditable coverage.
54.9801–6 Special enrollment periods.
54.9802–1 Prohibiting discrimination against participants and beneficiaries based on a health factor.
54.9802–2 Special rules for certain church plans.

54.9802–3T Additional requirements prohibiting discrimination based on genetic information (temporary).
54.9811–1 Standards relating to benefits for mothers and newborns.
54.9812–1T Parity in mental health and substance use disorder benefits (temporary).
54.9815–1251T Preservation of right to maintain existing coverage (temporary).
54.9815–2704T Prohibition of preexisting condition exclusions (temporary).
54.9815–2711T No lifetime or annual limits (temporary).
54.9815–2712T Rules regarding rescissions (temporary).
54.9815–2713 Coverage of preventive health services.
54.9815–2713T Coverage of preventive health services (temporary).
54.9815–2714T Eligibility of children until at least age 26 (temporary).
54.9815–2715 Summary of benefits and coverage and uniform glossary.
54.9815–2719AT Patient protections (temporary).
54.9815–2719T Internal claims and appeals and external review processes (temporary).
54.9831–1 Special rules relating to group health plans.
54.9833–1 Effective dates.

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Section 54.9811–1 also issued under 26 U.S.C. 9833;

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Section 54.9815–1251T also issued under 26 U.S.C. 9833;

Section 54.9815–2704T also issued under 26 U.S.C. 9833;

Section 54.9815–2711T also issued under 26 U.S.C. 9833;

Section 54.9815–2712T also issued under 26 U.S.C. 9833;

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EFFECTIVE DATE NOTE: By T.D. 9575, 77 FR 8697, Feb. 14, 2012, and by T.D. 9578, 77 FR 8729, Feb. 15, 2012, the authority citation for part 54 was ammended by adding entries for §54.9815–2715 and §54.9815–2713 in numerical order, effective Apr. 16, 2012. For the convenience of the user, the added text is set forth as follows:

AUTHORITY: 26 U.S.C. 7805. * * *

* * * * *

Section 54.9815–2713 also issued under 26 U.S.C. 9833.

* * * * *

Section 54.9815–2715 also issued under 26 U.S.C. 9833.

* * * * *

§ 54.4971–1 General rules relating to excise tax on failure to meet minimum funding standards.

(a)–(b) [Reserved]

(c) *Additional tax*. Section 4971(b) imposes an excise tax in any case in which an initial tax is imposed under section 4971(a) on an accumulated funding deficiency and the accumulated funding deficiency is not corrected within the taxable period (as defined in section 4971(c)(3)). The additional tax is 100 percent of the accumulated funding deficiency to the extent not corrected.

(d) [Reserved]

(e) *Definition of taxable period*—(1) *In general*. For purposes of any accumulated funding deficiency, the term ''taxable period'' means the period beginning with the end of the plan year in which there is an accumulated funding deficiency and ending on the earlier of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed by section 4971(a), or

(ii) The date on which the tax imposed by section 4971(a) is assessed.

(2) *Special rule*. Where a notice of deficiency referred to in paragraph (e)(1)(i) of this section is not mailed because a waiver of the restrictions on assessment and collection of a deficiency has been accepted or because the deficiency is paid, the date of filing of the waiver or the date of such payment, respectively, shall be treated as the end of the taxable period.

[T.D. 8084, 51 FR 16305, May 2, 1986]

§ 54.4972–1 Tax on excess contributions to plans benefiting self-employed individuals.

(a) *In general*. Section 4972 imposes a tax of 6 percent on the amount of the excess contributions (as defined in section 4972 (b) and (c) of this section) under certain qualified plans (as defined in paragraph (b) of this section) for each taxable year beginning after December 31, 1975, of the employer who maintains such plan. Partnerships and sole proprietors are to report this tax by filing Form 5330 (or other designated form) and the tax is to be paid annually at the time prescribed for filing such return (determined without regard to any extension of time for filing).

(b) *Employers to whom section applies*. The tax under section 4972 is imposed on employers who maintain a qualified plan during their taxable year. For this purpose, the term *qualified plan* means a pension or profit-sharing plan which includes a trust described in section 401(a), an annuity plan described in section 403(a), or a bond purchase plan described in section 405(a). In addition to being a qualified plan, the plan must provide contributions or benefits for employees some or all of whom are employees within the meaning of section 401(c)(1). For this purpose, the plan does not have to provide contributions or benefits for employees who are employees within the meaning of section 401(c)(1) during the taxable year; it is sufficient that the plan so provided in a prior taxable year.

(c) *Excess contributions*—(1) *In general*. For a taxable year of an employer for purposes of section 4972 and this section, the term ''excess contributions'' means:

(i) The amount (if any) by which the sum of:

(A) The amount (if any) determined under section 4972(b)(2) and paragraph (d) of this section, plus

(B) The amount (if any) determined under section 4972(b)(3) and paragraph (e) of this section, plus

(C) The amount (if any) determined under section 4972(b)(4) and paragraph (f) of this section, exceeds

(ii) The amount (if any) of any correcting distributions (as defined in section 4972(b)(5) and paragraph (g) of this

section) made in all prior taxable years beginning after December 31, 1975.

(2) *Contributions allocable to insurance.* For purposes of section 4972(b) and this section, the amount of any contribution made under the plan which is allocable to the purchase of life, accident, health, or other insurance is not taken into account. The amount of any contribution which is allocable to the cost of insurance protection is determined in accordance with the provisions of paragraph (g) of § 1.404(e)–1A and paragraph (b) of § 1.72–16.

(d) *Contributions by owner-employees*—(1) *General rule.* In the case of a plan which provides contributions or benefits for employees some or all of whom are owner-employees, within the meaning of section 401(c)(3), the amount determined under section 4972(b)(2) and this paragraph for the employer's taxable year is the amount computed separately with respect to each owner-employee equal to the sum of:

(i) The excess (if any) of

(A) The amount contributed under the plan by each owner-employee as an employee (that is, each owner-employee's contributions within the meaning of section 401(c)(5)(B)) for such taxable year of the employer, over

(B) The amount permitted under section 4972(c) and paragraph (h) of this section to be contributed by each owner-employee as an employee for such taxable year of the employer, and

(ii) The amount determined under section 4972(b)(2) and this paragraph for the immediately preceding taxable year of the employer, reduced by the excess (if any) of the amount described in subdivision (1)(B) of this subparagraph over the amount described in subdivision (1)(A) of this subparagraph for such taxable year of the employer.

(2) *Rollover amounts.* The provisions of section 4972 (c) and paragraph (d) of this section are not applicable to amounts contributed on behalf of an owner-employee in a rollover contribution described in section 402(a)(5), 403(a)(4), 408(d)(3), or 409(b)(3)(C).

(3) *Examples.* The provisions of this paragraph may be illustrated by the following examples:

Example 1. (i) A and B are the only owner-employees covered under the X Employees' Trust. The X Partnership, the X Trust, and the X Plan all use the calendar year as their annual accounting period, at all relevant times. The amount determined under section 4972(b)(2) for 1975 is 0 because this section does not apply to contributions made for taxable years beginning before January 1, 1976. In calendar year 1976, A contributes $2,500 and B contributes $2,500 to the trust. The amount permitted to be contributed to the trust for 1976 with respect to A as an employee is $1,800 and with respect to B as an employee is $2,200.

(ii) The amount determined under this paragraph for 1976 with respect to A is $700, computed as follows: the sum of the excess of the amount contributed by A ($2,500) over the amount permitted to be contributed by A ($1,800), and the amount determined under this paragraph for A in 1975 (0).

(iii) The amount determined under this paragraph for 1976 with respect to B is $300, computed as follows: the sum of the excess of the amount contributed by B ($2,500) over the amount permitted to be contributed by B ($2,200), and the amount determined under this paragraph for B in 1975 (0).

(iv) The amount determined under section 4972(b)(2) and this paragraph for 1976 with respect to the employer, X Partnership, is $1,000, the sum of the amounts determined separately under this paragraph with respect to A ($700) and B ($300). The tax under section 4972 for 1976 on the X Partnership (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $1,000 or $60.

Example 2. (i) Assume the facts stated in Example (1). In calendar year 1977, A contributes $1,500 and B contributes $2,300 to the trust. Assume that the amount permitted to be contributed to the trust for 1977, under section 4972(c) for A and B is $2,500 each.

(ii) The amount determined under this paragraph for 1977 with respect to A is 0, computed as follows: the sum of 0 (the excess of the amount contributed by A ($1,500) over the amount permitted to be contributed ($2,500)) and $700, the amount determined under this paragraph for A in 1976, reduced by $1,000 (the amount permitted to be contributed by A ($2,500) over the amount contributed by A ($1,500)).

(iii) The amount determined under this paragraph for 1977 with respect to B is $100, computed as follows: the sum of 0 (the excess of the amount contributed by B ($2,300) over the amount permitted to be contributed ($2,500)) and $300, the amount determined under this paragraph for B in 1976, reduced by $200 (the amount permitted to be contributed ($2,500) by B over the amount contributed by B ($2,300)).

(iv) The amount determined under section 4972(b) and this paragraph for 1977 with respect to the employer, X Partnership, is $100, the sum of the amounts determined separately under this paragraph with respect to

A ($0) and B ($100). The tax imposed under section 4972 for 1977 on the X Partnership (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $100, or $6.

(e) *Defined benefit plans*—(1) *General rule*. In the case of a defined benefit plan (as defined in section 414(j)), the amount determined under section 4972(b)(3) and this paragraph for the taxable year of the employer is the amount contributed under the plan by the employer during the taxable year plus the amounts, if any, contributed by the employer during any prior taxable year beginning after December 31, 1975, if:

(i) As of the close of the taxable year, the full funding limitation of the plan (determined under section 412(c)(7) and the regulations thereunder) is zero, and

(ii) Such amounts contributed have not been deductible by the employer for the taxable year or for any prior taxable year beginning after December 31, 1975.

See section 404 and the regulations thereunder for the determination of the amount deductible by the employer for the taxable year. If the amounts contributed by the employer exceed the amounts which have been deductible, the amount determined under this paragraph shall not exceed the amounts which have not been deductible. For purposes of this paragraph, the determination of both the amounts contributed and the amounts deductible by the employer for any relevant taxable year includes amounts contributed and deductible on behalf of any employee covered under the plan, including common-law employees and other self-employed individuals who are not owner-employees in addition to owner-employees. The determination of whether the full funding limitation is zero shall be made taking into account all the plan assets unreduced by any deduction carryover under section 404(a)(1)(D). The determination of whether the full funding limitation is zero as of the close of the employer's taxable year shall be made with respect to the plan year ending with or within the employer's taxable year. Consequently, if an employer whose taxable year is the calendar year establishes and maintains a defined benefit plan whose plan year begins on July 1 and ends on June 30, the full funding limitation for that plan will be determined with respect to the plan year ending on June 30 within the calendar taxable year including that June 30.

(2) *Illustration*. The provisions of this paragraph may be illustrated by the following example:

Example. (i) X Partnership (''X'') adopts the Y Defined Benefit Plan (''Y Plan'') on January 1, 1977. The taxable year of X is the calendar year. The Y Plan also has a calendar plan year. For 1977, $25,000 is contributed to the Y Plan by X. Assume that for 1977, (1) only $10,000 is deductible by X for 1977 under section 404 and (2) the full funding limitation of the Y Plan (determined under section 412(c)(7)) on December 31, 1977, is greater than zero. For 1978, X makes no additional contributions to the Y Plan. Assume that for 1978, (1) no amount is deductible by X under section 404 and (2) the full funding limitation of the Y Plan (determined under section 412(c)(7)) on December 31, 1978, is zero. The amount determined under section 4972(b)(3) and this paragraph for the 1978 taxable year is $15,000, computed as follows: the difference between (A) the sum of the amounts contributed by X for taxable year 1978 (0), and the amounts contributed by X for taxable year 1977 ($25,000) and (B) the sum of the amount deductible for taxable year 1978 (0) and the amount deductible for taxable year 1977 ($10,000). The tax imposed under section 4972 for 1978 on X (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $15,000 or $900.

(ii) For 1979, X makes no additional contributions to the Y Plan. Assume that for 1979, (1) the full funding limitation of the Y Plan determined under section 412(c)(7) is greater than zero. Assume further that $10,000 of the amounts contributed for 1977 is deductible by X for 1979 under section 404. There is no amount determined under section 4972(b)(3) and this paragraph for 1979 because the condition described in subparagraph (1)(i) of this paragraph is not satisfied.

(iii) For 1980, X makes no additional contributions to the Y Plan. Assume that for 1980, (1) no amount is deductible under section 404 and (2) the full funding limitation of the Y Plan (determined under section 412(c)(7)) on December 31, 1980, is zero. The amount determined under section 4972(b)(3) and this paragraph for the 1980 taxable year is $5,000, computed as follows: the difference between (A) $25,000, the sum of the amounts contributed by X for taxable years 1980 (0), 1979 (0), 1978 (0), and 1977 ($25,000) and (B) $20,000, the sum of the amounts deductible for taxable years 1980 (0), 1979 ($10,000), 1978 (0), and 1977 ($10,000). The tax imposed under

section 4972 for 1980 on X (assuming that no other events affecting the determination of the tax under section 4972 occur) is 6 percent of $5,000, or $300.

(f) *Defined contribution plans*—(1) *General rule*. In the case of a defined contribution plan (as defined in section 414(i)), the amount determined under section 4972(b)(4) and this paragraph for the taxable year of the employer is equal to the portion of the amounts contributed under the plan by the employer during the taxable year plus the amounts contributed by the employer during any prior taxable year beginning after December 31, 1975, which has not been deductible by the employer for the taxable year or for any such prior taxable year. For purposes of this paragraph, the determination of both the amounts contributed and the amounts deductible by the employer for any relevant taxable year includes amounts contributed and deductible on behalf of any employee covered under the plan, including common-law employees and other self-employed individuals who are not owner-employees in addition to owner-employees.

(2) *Illustration*. The provisions of this paragraph may be illustrated by the following example:

Example. (i) The X Partnership (''X'') adopts the Z Defined Contribution Plan and Trust (''Z Plan'') on January 1, 1976. X's taxable year and the plan year of Z Plan are both calendar years. For 1976, X contributes $40,000, of which $30,000 is deductible under section 404 for taxable year 1976. The amount determined under section 4972(b)(4) and this paragraph for 1976 is $10,000 (the difference between (A) $40,000, the amount contributed by X for taxable year 1976 and (B) $30,000, the amount deductible for taxable year 1976).

(ii) For 1977, X contributes $25,000, and the amounts deductible by X under section 404 for taxable year 1977 is $30,000 ($5,000 for the contribution carryover from 1976 and $25,000 with respect to the 1977 contribution). The amount determined under section 4972(b)(4) and this paragraph for 1977 is $5,000, computed as follows: the difference between (A) $65,000, the sum of the amounts contributed by X for taxable year 1976 ($40,000) and the amounts contributed by X for taxable year 1977 ($25,000), and (B) $60,000, the sum of the amounts deductible for taxable year 1976 ($30,000) and the amounts deductible for taxable year 1977 ($30,000).

(g) *Correcting distribution*—(1) *General rule*. For purposes of section 4972(b) and this paragraph, the term ''correcting distribution'' means, for the taxable year of the employer, the sum of:

(i) In the case of a contribution made as an employee by an owner-employee, within the meaning of section 401(c)(3), to a defined benefit or defined contribution plan, the amount, or any part thereof, determined under section 4972(b)(2) and paragraph (d) of this section which is distributed to the owner-employee who contributed such amount to the plan;

(ii) In the case of a defined benefit plan, the amount, or any part thereof, determined under section 4972(b)(3) and paragraph (e) of this section which is distributed from the plan to the employer, and

(iii) In the case of a defined contribution plan, the amount, or any part thereof, determined under section 4972(b)(4) and paragraph (f) of this section which is distributed to (A) the employer or (B) to the employee for whom such amount was contributed.

If, for any employer taxable year in which a defined contribution plan is maintained, there is a correcting distribution to an employee which could be from amounts described in subparagraph (1)(i) and (iii) of this paragraph for such employee, then such correcting distribution shall be deemed to be made first from amounts described in such subparagraph (1)(i) and then from amounts described in such subparagraph (1)(iii) for purposes of this section and section 72. For the income tax treatment of such distributions to employees, see section 72 and the regulations thereunder. Any such distributions to employees shall not be subject to the tax imposed by section 4975 nor result in the defined contribution plan failing to satisfy the exclusive benefit requirement of section 401(a), solely by reason of being a correcting distribution within the meaning of this paragraph. If, for any employer taxable year in which a defined benefit, or defined contribution plan is maintained, there is a correcting distribution described in subparagraph (1)(ii) or (iii) of this paragraph to the employer maintaining the plan, such distribution shall not be subject to the tax imposed by section 4975 nor result in the plan's failing to satisfy the exclusive benefit

or the definitely determinable requirements under section 401(a). If, for any employer taxable year in which a money purchase pension plan is maintained, a correcting distribution described in subparagraph (1)(iii) of this paragraph is made to an employee who has not yet become eligible to receive retirement benefits under the plan, the qualification of the pension plan (and trust) under section 401(a) may be adversely affected. See § 1.401–1(b)(1)(i). A correcting distribution described in subparagraph (1)(iii) of this paragraph to an owner-employee prior to age 59½ must be precluded under the plan. See section 401(d)(4)(B).

(2) *Illustration*. The provisions of this paragraph may be illustrated by the following example:

Example. (i) A and B are owner-employees who are over the age of 59½ and who are covered under the X Employees' Defined Contribution Plan and Profit-Sharing Trust (''Plan Y''). The X Partnership (''X'') and Plan Y are on calendar years. In calendar year 1976, A contributes $2,500 and B contributes $2,500 to Plan Y. The amount permitted to be contributed to Plan Y for 1976 with respect to A as an employee is $1,800 and with respect to B as an employee is $2,200. X contributes to Plan Y $5,000 on behalf of A and $5,000 on behalf of B. Of this amount, assume that $2,700 is deductible with respect to A and $3,300 is deductible with respect to B by X under section 404. The amount determined under section 4972(b)(2) and paragraph (d) of this section (the excess owner-employee contributions made by A and B to Plan Y) for taxable year 1976 is $1,000, computed as follows: the sum of (A) for A, $700, the difference between his own contributions ($2,500) and the amount permitted to be contributed by A ($1,800) and (B) for B, $300, the difference between his own contributions ($2,500) and the amount permitted to be contributed by B ($2,200). The amount determined under section 4972(b)(4) and paragraph (f) of this section (the excess contributions made by X to Plan Y) for taxable year 1976 is $4,000, computed as follows: the sum of (A) by X for A, $2,300, the difference between contributions by X ($5,000) and the amount deductible by X for A ($2,700) and (B) by X for B, $1,700, the difference between contributions by X for B ($5,000) and the amount deductible by X for B ($3,300). During 1976, there is no correcting distribution, within the meaning of section 4972 and this paragraph, because there are no distributions to A, B, or X.

(ii) Assume that, for taxable year 1977, the amounts determined under sections 4972(b)(2) and 4972(b)(4) remain the same as for taxable year 1976, that is, $1,000 ($700 for A and $300 for B) and $4,000 ($2,300 by X for A and $1,700 by X for B), respectively. Assume further that, in 1977, Plan Y distributes $3,000 to A and $1,000 to B. The amount determined under section 4972(b)(5) and this paragraph (the correcting distribution for Plan Y) for taxable year 1977 is $4,000, computed and attributed as follows: the sum of (A) $3,000 with respect to A, the amount of the distribution to A applied first to A's $700 amount described in subparagraph (1)(i) of this paragraph and next to A's $2,300 amount described in subparagraph (1)(iii) of this paragraph and (B) $1,000 with respect to B, the amount of the distribution to B applied first to B's $300 amount described in subparagraph (1)(i) of this paragraph and next to B's $1,700 amount described in subparagraph (1)(iii) of this paragraph. For purposes of computing the excess contributions for taxable year 1977, the correcting distribution of $4,000 would not be taken into account because only correcting distributions for prior year are considered. However, for taxable year 1978 the correcting distribution of $4,000 would be taken into account.

(iii) Assume that, for taxable year 1978, there are no additional amounts determined under sections 4972(b)(2) and 4972(b)(4) and that Plan Y distributes $900 to B. The amount determined under section 4972(b)(5) and this paragraph (the correcting distribution for Plan Y) for the 1978 taxable year is $900, computed and attributed as follows: the amount of the distribution to B, $900, applied to B's $1,000 amount described in subparagraph (1)(iii) of this paragraph. For purposes of computing the excess contributions for taxable year 1978, the correcting distribution of $900 would not be taken into account. However, for taxable year 1979, the correcting distribution of $900 would be taken into account.

(h) *Amount permitted to be contributed by owner-employee*—(1) *General rule*. Except as provided in subparagraph (2), for purposes of section 4972(b)(2) and paragraph (d), the amount permitted to be contributed under a plan by an owner-employee as an employee for any taxable year of the employer is the smallest of the following:

(i) $2,500;

(ii) 10 percent of the earned income (as defined in section 401(c)(2)) for such taxable year derived by the owner-employee from the trade or business with respect to which the plan is established, or

(iii) The amount of the contribution which would be contributed by the owner-employee (as an employee) if such contribution were made at the

rate of contributions which is permitted to be made by employees who are not owner-employees during such taxable year.

(2) *Special rule*. In the case of a taxable year of the employer in which there are no employees other than owner-employees, the amount permitted to be contributed under a plan by an owner-employee (as an employee) is zero.

(i) *Special rules and cross references*—(1) *Time of contributions*. For purposes of this section, time of employer contributions made with respect to any taxable year shall take into account the rules specified in section 404(a)(6), relating to time when contributions deemed made.

(2) *Disallowance of deduction*. For disallowance of deduction for taxes paid under this section, see section 275(a)(6).

(3) *Certain annuity contracts*. For a special rule relating to owner-employee contributions for premiums on annuity, etc. contracts, see § 1.401(e)4(a)

(4) *Disqualification for excess contributions*. For plan qualification requirements relating to excess contributions, see section 401(d)(5).

[T.D. 7759, 46 FR 6932, Jan. 22, 1981]

§ 54.4974–1 Excise tax on accumulations in individual retirement accounts or annuities.

(a) *General rule*. A tax equal to 50 percent of the amount by which the minimum amount required to be distributed from an individual retirement account or annuity described in section 408 during the taxable year of the payee under paragraph (b) of this section exceeds the amount actually distributed during the taxable year is imposed by section 4974 on the payee.

(b) *Minimum amount required to be distributed*. For purposes of this section, the minimum amount required to be distributed is the amount required under § 1.408–2(b)(6)(v) to be distributed in the taxable year described in paragraph (a) of this section.

(c) *Examples*. The application of this section may be illustrated by the following examples.

Example 1. In 1975, the minimum amount required to be distributed under § 1.408–2(b)(6)(v) to A under his individual retirement account is $100. Only $60 is actually distributed to A in 1975. Under section 4974, A would have an excise tax liability of $20 [50% of ($100 − $60)].

Example 2. Although no distribution is required under § 1.408–2(b)(6)(v) to be made in 1986, H, a married individual born on February 1, 1921, who has established and maintained an individual retirement account decides to begin receiving distributions from the account beginning in 1986. H's wife, W, was born on March 6, 1921. H and W are calendar year taxpayers. H decides to receive his interest in the account over the joint life and last survivor expectancy of himself and his wife. On January 1, 1986, the balance in H's account is $10,000; H and W, based on their nearest birthdates, are 65; and the joint life and last survivor expectancy of H and his wife is 22.0 years (see Table II of § 1.72–9). His annual payments during the following years (none of which were required) were determined by dividing the balance in the account on the first day of each year by the joint life and last survivor expectancy reduced by the number of whole years elapsed since the distributions were to commence.

Date	Life expectancy minus whole years elapsed	Account balance at beginning of each year	Annual payment
Jan. 1, 1986	22.0	$10,000	$455
Jan. 1, 1987	21.0	10,118	482
Jan. 1, 1988	20.0	10,214	511
Jan. 1, 1989	19.0	10,285	541
Jan. 1, 1990	18.0	10,329	574
Jan. 1, 1991	17.0	10,340	608

For 1986, 1987, 1989, and 1990, the amount required to be distributed under § 1.408–2(b)(6)(v) is zero. Thus, H would have no excise tax liability under section 4974 for these years. In 1991, the year H attains age 70½, the amount required to be distributed from the account under § 1.408–2(b)(6)(v) is $565, determined by dividing $10,340 (the account balance as of January 1, 1991) by 18.8 years (the joint life and last survivor expectancy of H and W, assuming they are both still living, as of January 1, 1991). If W should die after December 31, 1990, the joint life and last survivor expectancy determined on January 1, 1991 (18.3 years) would not be redetermined. Because the amount distributed from the account in 1991 ($608) exceeds the amount required to be distributed from the account in 1991 ($565), H has no excise tax liability under section 4974 for 1991.

Example 3. Assume the same facts as in example (2) except that W dies in 1988. For 1988, 1989, and 1990, the amount required to be distributed under § 1.408–2(b)(6)(v) is zero. Thus, H would have no excise tax liability under section 4974 for these years. In 1991, the amount required to be distributed under

§ 1.408–2(b)(6)(v) is $855, determined by dividing $10,340 (the account balance as of January 1, 1991) by 12.1 years (the life expectancy of H as of January 1, 1991). Because the amount distributed from the account in 1991 ($608) is less than the amount required to be distributed from the account in 1991 ($855), H has an excise tax liability of $123.50 under section 4974 for 1991 [50% of ($855 – $608)].

[T.D. 7714, 45 FR 52799, Aug. 8, 1980]

§ 54.4974–2 Excise tax on accumulations in qualified retirement plans.

Q–1. Is any tax imposed on a payee under any qualified retirement plan or any eligible deferred compensation plan (as defined in section 457(b)) to whom an amount is required to be distributed for a taxable year if the amount distributed during the taxable year is less than the required minimum distribution?

A–1. Yes, if the amount distributed to a payee under any qualified retirement plan or any eligible deferred compensation plan (as defined in section 457(b)) for a calendar year is less than the required minimum distribution for such year, an excise tax is imposed on such payee under section 4974 for the taxable year beginning with or within the calendar year during which the amount is required to be distributed. The tax is equal to 50 percent of the amount by which such required minimum distribution exceeds the actual amount distributed during the calendar year. Section 4974 provides that this tax shall be paid by the payee. For purposes of section 4974, the term required minimum distribution means the minimum distribution amount required to be distributed pursuant to section 401(a)(9), 403(b)(10), 408(a)(6), 408(b)(3), or 457(d)(2), as the case may be, and the regulations thereunder. Except as otherwise provided in A–6 of this section, the required minimum distribution for a calendar year is the required minimum distribution amount required to be distributed during the calendar year. A–6 of this section provides a special rule for amounts required to be distributed by an employee's (or individual's) required beginning date.

Q–2. FOR PURPOSES OF SECTION 4974, WHAT IS A QUALIFIED RETIREMENT PLAN?

A–2. For purposes of section 4974, each of the following is a qualified retirement plan—

(a) A plan described in section 401(a) which includes a trust exempt from tax under section 501(a);

(b) An annuity plan described in section 403(a);

(c) An annuity contract, custodial account, or retirement income account described in section 403(b);

(d) An individual retirement account described in section 408(a) (including a Roth IRA described in section 408A);

(e) An individual retirement annuity described in section 408(b) (including a Roth IRA described in section 408A); or

(f) Any other plan, contract, account, or annuity that, at any time, has been treated as a plan, account, or annuity described in paragraphs (a) through (e) of this A–2, whether or not such plan, contract, account, or annuity currently satisfies the applicable requirements for such treatment.

Q–3. If a payee's interest under a qualified retirement plan is in the form of an individual account, how is the required minimum distribution for a given calendar year determined for purposes of section 4974?

A–3. (a) *General rule.* If a payee's interest under a qualified retirement plan is in the form of an individual account and distribution of such account is not being made under an annuity contract purchased in accordance with A–4 of § 1.401(a)(9)–6, the amount of the required minimum distribution for any calendar year for purposes of section 4974 is the required minimum distribution amount required to be distributed for such calendar year in order to satisfy the minimum distribution requirements in § 1.401(a)(9)–5 as provided in the following (whichever is applicable)—

(1) Section 401(a)(9) and §§ 1.401(a)(9)–1 through 1.401(a)(9)–5 and 1.401(a)(9)–7 through 1.401(a)(9)–9 in the case of a plan described in section 401(a) which includes a trust exempt under section 501(a) or an annuity plan described in section 403(a);

(2) Section 403(b)(10) and § 1.403(b)–6(e) (in the case of an annuity contract,

custodial account, or retirement income account described in section 403(b));

(3) Section 408(a)(6) or (b)(3) and § 1.408–8 (in the case of an individual retirement account or annuity described in section 408(a) or (b)); or

(4) Section 457(d) in the case of an eligible deferred compensation plan (as defined in section 457(b)).

(b) *Default provisions.* Unless otherwise provided under the qualified retirement plan (or, if applicable, the governing instrument of the qualified retirement plan), the default provisions in A–4(a) of § 1.401(a)(9)–3 apply in determining the required minimum distribution for purposes of section 4974.

(c) *Five-year rule.* If the 5-year rule in section 401(a)(9)(B)(ii) applies to the distribution to a payee, no amount is required to be distributed for any calendar year to satisfy the applicable enumerated section in paragraph (a) of this A–3 until the calendar year which contains the date 5 years after the date of the employee's death. For the calendar year which contains the date 5 years after the employee's death, the required minimum distribution amount required to be distributed to satisfy the applicable enumerated section is the payee's entire remaining interest in the qualified retirement plan.

Q–4. If a payee's interest in a qualified retirement plan is being distributed in the form of an annuity, how is the amount of the required minimum distribution determined for purposes of section 4974?

A–4. If a payee's interest in a qualified retirement plan is being distributed in the form of an annuity (either directly from the plan, in the case of a defined benefit plan, or under an annuity contract purchased from an insurance company), the amount of the required minimum distribution for purposes of section 4974 will be determined as follows:

(a) *Permissible annuity distribution option.* A permissible annuity distribution option is an annuity contract (or, in the case of annuity distributions from a defined benefit plan, a distribution option) which specifically provides for distributions which, if made as provided, would for every calendar year equal or exceed the minimum distribution amount required to be distributed to satisfy the applicable section enumerated in paragraph (a) of A–2 of this section for every calendar year. If the annuity contract (or, in the case of annuity distributions from a defined benefit plan, a distribution option) under which distributions to the payee are being made is a permissible annuity distribution option, the required minimum distribution for a given calendar year will equal the amount which the annuity contract (or distribution option) provides is to be distributed for that calendar year.

(b) *Impermissible annuity distribution option.* An impermissible annuity distribution option is an annuity contract (or, in the case of annuity distributions from a defined benefit plan, a distribution option) under which distributions to the payee are being made that specifically provides for distributions which, if made as provided, would for any calendar year be less than the minimum distribution amount required to be distributed to satisfy the applicable section enumerated in paragraph (a) of A–3 of this section. If the annuity contract (or, in the case of annuity distributions from a defined benefit plan, the distribution option) under which distributions to the payee are being made is an impermissible annuity distribution option, the required minimum distribution for each calendar year will be determined as follows:

(1) If the qualified retirement plan under which distributions are being made is a defined benefit plan, the minimum distribution amount required to be distributed each year will be the amount which would have been distributed under the plan if the distribution option under which distributions to the payee were being made was the following permissible annuity distribution option:

(i) In the case of distributions commencing before the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the permissible annuity distribution option is the joint and survivor annuity option under the plan for the lives of the employee and the designated beneficiary that provides for the greatest level amount payable

to the employee determined on an annual basis. If the plan does not provide such an option or there is no designated beneficiary under the impermissible distribution option for purposes of section 401(a)(9), the permissible annuity distribution option is the life annuity option under the plan payable for the life of the employee in level amounts with no survivor benefit.

(ii) In the case of distributions commencing after the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the permissible annuity distribution option is the life annuity option under the plan payable for the life of the designated beneficiary in level amounts. If there is no designated beneficiary, the 5-year rule in section 401(a)(9)(B)(ii) applies. See paragraph (b)(3) of this A–4. The determination of whether or not there is a designated beneficiary and the determination of which designated beneficiary's life is to be used in the case of multiple beneficiaries will be made in accordance with §1.401(a)(9)–4 and A–7 of §1.401(a)(9)–5. If the defined benefit plan does not provide for distribution in the form of the applicable permissible distribution option, the required minimum distribution for each calendar year will be an amount as determined by the Commissioner.

(2) If the qualified retirement plan under which distributions are being made is a defined contribution plan and the impermissible annuity distribution option is an annuity contract purchased from an insurance company, the minimum distribution amount required to be distributed each year will be the amount that would have been distributed in the form of an annuity contract under the permissible annuity distribution option under the plan determined in accordance with paragraph (b)(1) of this A–4 for defined benefit plans. If the defined contribution plan does not provide the applicable permissible annuity distribution option, the required minimum distribution for each calendar year will be the amount that would have been distributed under an annuity described in paragraph (b)(2)(i) or (ii) of this A–4 purchased with the employee's or individual's account used to purchase the annuity contract that is the impermissible annuity distribution option.

(i) In the case of distributions commencing before the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the annuity is a joint and survivor annuity for the lives of the employee and the designated beneficiary which provides level annual payments and which would have been a permissible annuity distribution option. However, the amount of the periodic payment which would have been payable to the survivor will be the applicable percentage under the table in A–2(c) of §1.401(a)(9)–6 of the amount of the periodic payment which would have been payable to the employee or individual. If there is no designated beneficiary under the impermissible distribution option for purposes of section 401(a)(9), the annuity is a life annuity for the life of the employee with no survivor benefit which provides level annual payments and which would have been a permissible annuity distribution option.

(ii) In the case of a distribution commencing after the death of the employee, if there is a designated beneficiary under the impermissible annuity distribution option for purposes of section 401(a)(9), the annuity option is a life annuity for the life of the designated beneficiary which provides level annual payments and which would have been a permissible annuity distribution option. If there is no designated beneficiary, the 5-year rule in section 401(a)(9)(B)(ii) applies. See paragraph (b)(3) of this A–4. The amount of the payments under the annuity contract will be determined using the interest rate and actuarial tables prescribed under section 7520 determined using the date determined under A–3 of §1.401(a)(9)–3 when distributions are required to commence and using the age of the beneficiary as of the beneficiary's birthday in the calendar year that contains that date. The determination of whether or not there is a designated beneficiary and the determination of which designated beneficiary's life is to be used in the case of multiple beneficiaries will be

made in accordance with § 1.401(a)(9)–4 and A–7 of § 1.401(a)(9)–5.

(3) If the 5-year rule in section 401(a)(9)(B)(ii) applies to the distribution to the payee under the contract (or distribution option), no amount is required to be distributed to satisfy the applicable enumerated section in paragraph (a) of this A–4 until the calendar year which contains the date 5 years after the date of the employee's death. For the calendar year which contains the date 5 years after the employee's death, the required minimum distribution amount required to be distributed to satisfy the applicable enumerated section is the payee's entire remaining interest in the annuity contract (or under the plan in the case of distributions from a defined benefit plan).

(4) If the plan provides that the required beginning date for purposes of section 401(a)(9) for all employees is April 1 of the calendar year following the calendar year in which the employee attained age 70½ in accordance with paragraph A–2(e) of § 1.401(a)(9)–2, the required minimum distribution for each calendar year for an employee who is not a 5-percent owner for purposes of this section will be the lesser of the amount determined based on the required beginning date as set forth in A–2(a) of § 1.401(a)(9)–2 or the required beginning date under the plan. Thus, for example, if an employee dies after attaining age 70½, but before April 1 of the calendar year following the calendar year in which the employee retired, and there is no designated beneficiary as of September 30 of the year following the employee's year of death, required minimum distributions for calendar years after the calendar year containing the employee's date of death may be based on either the applicable distribution period provided under either the 5-year rule of A–1 of § 1.401(a)(9)–3 or the employee's remaining life expectancy as set forth in A–5(c)(3) of § 1.401(a)(9)–5.

Q–5. If there is any remaining benefit with respect to an employee (or IRA owner) after any calendar year in which the entire remaining benefit is required to be distributed under section 401(a)(9), what is the amount of the required minimum distribution for each calendar year subsequent to such calendar year?

A–5. If there is any remaining benefit with respect to an employee (or IRA owner) after the calendar year in which the entire remaining benefit is required to be distributed, the required minimum distribution for each calendar year subsequent to such calendar year is the entire remaining benefit.

Q–6. With respect to which calendar year is the excise tax under section 4974 imposed in the case in which the amount not distributed is an amount required to be distributed by April 1 of a calendar year (by the employee's or individual's required beginning date)?

A–6. In the case in which the amount not paid is an amount required to be paid by April 1 of a calendar year, such amount is a required minimum distribution for the previous calendar year, *i.e.*, for the employee's or the individual's first distribution calendar year. However, the excise tax under section 4974 is imposed for the calendar year containing the last day by which the amount is required to be distributed, *i.e.*, the calendar year containing the employee's or individual's required beginning date, even though the preceding calendar year is the calendar year for which the amount is required to be distributed. There is also a required minimum distribution for the calendar year which contains the employee's or individual's required beginning date. Such distribution is also required to be made during the calendar year which contains the employee's or individual's required beginning date.

Q–7. Are there any circumstances when the excise tax under section 4974 for a taxable year may be waived?

A–7. (a) *Reasonable cause.* The tax under section 4974(a) may be waived if the payee described in section 4974(a) establishes to the satisfaction of the Commissioner the following—

(1) The shortfall described in section 4974(a) in the amount distributed in any taxable year was due to reasonable error; and

(2) Reasonable steps are being taken to remedy the shortfall.

(b) *Automatic waiver.* The tax under section 4974 will be automatically waived, unless the Commissioner determines otherwise, if—

(1) The payee described in section 4974(a) is an individual who is the sole beneficiary and whose required minimum distribution amount for a calendar year is determined under the life expectancy rule described in § 1.401(a)(9)–3 A–3 in the case of an employee's or individual's death before the employee's or individual's required beginning date; and

(2) The employee's or individual's entire benefit to which that beneficiary is entitled is distributed by the end of the fifth calendar year following the calendar year that contains the employee's or individual's date of death.

[T.D. 8987, 67 FR 19026, Apr. 17, 2002; 67 FR 35732, May 21, 2002, as amended by T.D. 9340, 72 FR 41160, July 26, 2007]

§ 54.4975–1 General rules relating to excise tax on prohibited transactions.

(a) *Scope*. This section provides general rules for the imposition of the excise taxes on prohibited transactions.

(b) *Initial tax*. Section 4975(a) imposes an initial tax on each prohibited transaction. The initial tax is 5 percent of the amount involved with respect to the prohibited transaction for each year (or part thereof) in the taxable period.

(c) *Additional tax*. Section 4975(b) imposes an excise tax in any case in which an initial tax is imposed under section 4975(a) on a prohibited transaction and the prohibited transaction is not corrected within the taxable period (as defined in paragraph (d) of this section). The additional tax is 100 percent of the amount involved with respect to the prohibited transaction.

(d) *Taxable period*—(1) *In general*. For purposes of any prohibited transaction, the term ''taxable period'' means the period beginning with the date on which the prohibited transaction occurs and ending on the earliest of:

(i) The date of mailing of a notice of deficiency under section 6212 with respect to the tax imposed by section 4975(a);

(ii) The date on which correction of the prohibited transaction is completed; or

(iii) The date on which the tax imposed by section 4975(a) is assessed.

(2) *Special rule*. Where a notice of deficiency referred to in paragraph (d)(1)(i) of this section is not mailed because a waiver of the restrictions on assessment and collection of a deficiency has been accepted or because the deficiency is paid, the date of filing of the waiver or the date of such payment, respectively, shall be treated as the end of the taxable period.

[T.D. 8084, 51 FR 16305, May 2, 1986]

§ 54.4975–6 Statutory exemptions for office space or services and certain transactions involving financial institutions.

(a) *Exemption for office space or services*—(1) *In general*. Section 4975(d)(2) exempts from the excise taxes imposed by section 4975 payment by a plan to a disqualified person, including a fiduciary, for office space or any service (or a combination of services), if (i) such office space or service is necessary for the establishment or operation of the plan; (ii) such office space or service is furnished under a contract or arrangement which is reasonable; and (iii) no more than reasonable compensation is paid for such office space or service. However, section 4975(d)(2) does not contain an exemption for acts described in section 4975(c)(1)(E) (relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account) or acts described in section 4975(c)(1)(F) (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). Such acts are separate transactions not described in section 4975(d)(2). See §§ 54.4975–6(a)(5) and 54.4975–6(a)(6) for guidance as to whether transactions relating to the furnishing of office space or services by fiduciaries to plans involve acts described in section 4975(c)(1)(E).

Section 4975(d)(2) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(2). See, for example, the general fiduciary responsibility provisions of section 404 of the

Employee Retirement Income Security Act of 1974 (the Act) (88 Stat. 877). The provisions of section 4975(d)(2) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *Necessary service.* A service is necessary for the establishment or operation of a plan within the meaning of section 4975(d)(2) and § 54.4975–6(a)(1)(i) 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 disqualified person solely by reason of a relationship to such a service provider described in section 4975(e)(2) (F), (G), (H), or (I)) 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.

(3) *Reasonable contract or arrangement.* No contract or arrangement is reasonable within the meaning of section 4975(d)(2) and § 54.4975–6(a)(1)(ii) 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.

Similarly, a provision in a lease for a termination fee that covers reasonably foreseeable expenses related to the vacancy and reletting 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 payments in excess of actual loss or if it fails to require mitigation of damages.

(4) *Reasonable compensation.* Section 4975(d)(2) and § 54.4975–6(a)(1)(iii) permit a plan to pay a disqualified person reasonable compensation for the provision of office space or services described in section 4975(d)(2). Paragraph (e) of this section contains regulations relating to what constitutes reasonable compensation for the provision of services.

(5) *Transactions with fiduciaries*—(i) *In general.* If the furnishing of office space or a service involves an act described in section 4975(c)(1) (E) or (F) (relating to acts involving conficts of interest by fiduciaries), such an act constitutes a separate transaction which is not exempt under section 4975(d)(2). The prohibitions of sections 4975(c)(1) (E) and (F) supplement the other prohibitions of section 4975(c)(1) by imposing on disqualified persons 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 disqualified person by reason of a relationship to such fiduciary described in section 4975(e)(2) (E), (F), (G), (H), or (I).

(ii) *Transactions not described in section 4975(c)(1)(E).* A fiduciary does not engage in an act described in section 4975(c)(1)(E) 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.

(iii) *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 paragraph (e)(4) of this section), the provision of such services does not, in and of itself, constitute an act described in section 4975(c)(1) (E) or (F). The allowance of a deduction to an employer under section 162 or 212 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.

(6) *Examples.* The provisions of § 54.4975–6(a)(5) may be illustrated by the following examples:

Example 1. E, an employer whose employees are covered by plan P, is a fiduciary or 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 4975(e)(3)(B). 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 4975(c)(1)(E), 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 4975(c)(1)(E). E, as the fiduciary who has the responsibility to be prudent in his selection and retention of I and the other investments 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 disqualified person 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 by 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 4975(c)(1)(E) (as well as section 4975(c)(1)(F), 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 4975(c)(1) 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 4975(c)(1) (E) or (F), 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 disqualified person 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 § 54.4975–9(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 4975(c)(1)(E), 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 4975(e)(3)(C). 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 4975(c)(1)(E). 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 4975(c)(1)(E).

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 4975(c)(1)(E), 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 4975(d)(2) 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 4975(c)(1)(E). Further, the other trustees have not engaged in an act described in section 4975(c)(1)(E) 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.

(b) *Exemption for bank deposits*—(1) *In general.* Section 4975(d)(4) exempts from the excise taxes imposed by section 4975 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 institution is a fiduciary or other disqualified person with respect to the plan, if the conditions of either § 54.4975–6(b)(2) or § 54.4975–6(b)(3) are met. Section 4975(d)(4) provides an exemption from section 4975(c)(1)(E) relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account), as well as sections 4975(c)(1) (A) through (D), because section 4975(d)(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 4975(d)(4) are met. However, it does not provide an exemption from section 4975(c)(1)(F) (relating to fidiciaries 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). The receipt of such consideration is a separate transaction not described in the exemption. Section 4975(d)(4) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(4). See, for example, the general fiduciary responsibility provisions of section 404 of the Act. The provisions of section 4975(d)(4) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *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.

(3) *Other plans*—(i) *General rule.* 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 constitute an act described in section 4975(c)(1) (E) or (F). 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.)

(ii) *Example.* B, a bank, is the trustee of plan P's assets. The trust instruments give the trustee 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 4975(d)(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.

(4) *Definitions.* (i) The term ''bank or similar financial institution'' includes a bank (as defined in section 581), a domestic building and loan association (as defined in section 7701(a)(19)), and a credit union (as defined in section 101 (6) of the Federal Credit Union Act).

(ii) 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) and the regulations thereunder.

(iii) 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.

(c) *Exemption for ancillary bank services*—(1) *In general.* Section 4975(d)(6) exempts from the excise taxes imposed by section 4975 the provision of certain ancillary services by a bank or similar financial institution (as defined in § 54.4975–6(b)(4)(i)) supervised by the United States or a State to a plan for which it acts as a fiduciary if the conditions in § 54.4975–6(c)(2) are met. Such ancillary services include services which do not meet the requirements of section 4975(d)(2), because the provision of such services involves an act described in section 4975(c)(1)(E) (relating to fiduciaries dealing with the income or assets of plans in their own interest or for their own account) by the fiduciary bank or similar financial institution. Section 4975(d)(6) provides an exemption from section 4975(c)(1)(E), because section 4975 (d)(6) contemplates the provision of such ancillary services without the approval of a second fiduciary (as described in § 54.4975–6(a)(5)(ii)) if the conditions of § 54.4975–6(c)(2) 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 § 54.4975–6(c)(2) are met, notwithstanding the provisions of section 4975(d)(4) (relating to investments in bank deposits). However, section 4975(d)(6) does not provide an exemption for an act described in section

4975(c)(1)(F) (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). The receipt of such consideration is a separate transaction not described in section 4975(d)(6).

Section 4975(d)(6) does not contain an exemption from other provisions of the Code, such as section 401, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 4975(d)(6). See, for example, the general fiduciary responsibility provisions of section 404 of the Act. The provisions of section 4975(d)(6) are further limited by the flush language at the end of section 4975(d) (relating to transactions with owner-employees and related persons).

(2) *Conditions.* Such service must be provided:

(i) At not more than reasonable compensation;

(ii) 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

(iii) 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 § 54.4975–6(c)(3).

(3) *Specific guidelines.* [Reserved]

(d) *Exemption for services as a fiduciary.* [Reserved]

(e) *Compensation for services*—(1) *In general.* Section 4975(d)(2) refers to the payment of reasonable compensation by a plan to a disqualified person for services rendered to the plan. Section 4975(d)(10) and §§ 54.4975–6(e)(2) through 54.4975–6(e)(5) clarify what constitutes reasonable compensation for such services.

(2) *General rule.* Generally, whether compensation is ''reasonable'' under sections 4975(d) (2) and (10) depends on the particular facts and circumstances of each case.

(3) *Payments to certain fiduciaries.* Under sections 4975(d) (2) and (10), 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 (e)(3) do not apply to a disqualified person who is not a fiduciary.

(4) *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.

(5) *Expense advances.* Under sections 4975(d) (2) and (10), 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.

(6) *Excessive compensation.* Under sections 4975(d) (2) and (10), any compensation which would be considered excessive under § 1.162–7 (relating to compensation for personal services which constitutes 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 § 1.162–7 may, nevertheless, not be ''reasonable compensation'' within the meaning of sections 4975(d) (2) and (10).

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§ 54.4975–7 Other statutory exemptions.

(a) [Reserved]

(b) *Loans to employee stock ownership plans*—(1) *Definitions.* When used in this

paragraph (b) and § 54.4975–11, the terms listed below have the following meanings:

(i) *ESOP*. The term ''ESOP'' refers to an employee stock ownership plan that meets the requirements of section 4975(e)(7) and § 54.4975–11. 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) and § 54.4975–11 will not be adversely affected merely because it engages in a non-exempt loan.

(ii) *Loan*. The term ''loan'' refers to a loan made to an ESOP by a disqualified person or a loan to an ESOP which is guaranteed by a disqualified person. 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 disqualified person 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.

(iii) *Exempt loan*. The term ''exempt loan'' refers to a loan that satisfies the provisions of this paragraph (b). A ''nonexempt loan'' is one that fails to satisfy such provisions.

(iv) *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).

(v) *Qualifying employer security*. The term ''qualifying employer security'' refers to a security described in § 54.4975–12.

(2) *Statutory exemption*—(i) *Scope*. Section 4975(d)(3) provides an exemption from the excise tax imposed under section 4975 (a) and (b) by reason of section 4975(c)(1) (A) through (E). Section 4975(d)(3) does not provide an exemption from the imposition of such tax by reason of section 4975(c)(1)(F), 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.

(ii) *Special scrutiny of transaction*. The exemption under section 4975(d)(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 those potential abuses, the Internal Revenue Service 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 exercise scrupulously 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 paragraph (b)(3)(ii) and (iii) 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.

(3) *Primary benefit requirement*—(i) *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 paragraph (b) (3) (ii) and (iii) of this section, will be considered in determining whether the loan satisfies this requirement. However, no loan will satisfy the requirement unless it satisfies the requirements of paragraph (b) (4), (5), and (6) of this section.

(ii) *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.

(iii) *Arm's-length standard*. The terms of a loan, whether or not between independent parties, must, at the same 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.

(4) *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:

(i) To acquire qualifying employer securities.

(ii) To repay such loan.

(iii) To repay a prior exempt loan. A new loan, the proceeds of which are so used, must satisfy the provisions of this paragraph (b).

Except as provided in paragraph (b) (9) and (10) 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 an ESOP.

(5) *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 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:

(i) Collateral given for the loan,

(ii) Contributions (other than contributions of employers securities) that are made under an ESOP to meet its obligations under the loan, and

(iii) 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.

(6) *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 disqualified person, 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 subparagraph (6), the making of a guarantee does not make a person a lender.

(7) *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.

(8) *Release from encumbrance*—(i) *General rule.* In general, an exempt loan must provide for the release from encumbrance under this subdivision (i) of plan assets used as collateral for the loan. 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 §54.4975–7(b) (8) (iv). 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.

(ii) *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 amoritization tables. The third rule is that this subdivision, (ii) 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.

(iii) *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 § 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 to these allocations, under § 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. At the same time, release from encumbrance in annual 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). The Internal Revenue Service will observe closely the operation of ESOP's that release encumbered securities in varying annual amounts, particularly those that provide for the deferral of loan payments or for balloon payments.

(iv) *Illustration*. The general rule under paragraph (b)(8)(i) of this section operates as illustrated in the following example:

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 loan proceeds 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.

(9) *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 subparagraph (9). Securities subject to such right must be stock or an equity security, or a debt security convertible into stock or an equity security. Also, the securities 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 § 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.

(10) *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 subparagraph (10), a ''trading limitation'' on a security is a restriction under any Federal or state securities law, any regulation thereunder, or an agreement, not prohibited by this paragraph (b), affecting the security which would make the security not as freely tradable 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 subparagraph (10), *participant* means a participant and 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.

(11) *Duration of put option*—(i) *General rule*. A put option must be exercisable at least during a 15-month period which begins on the date the security subject to the put option is distributed by the ESOP.

(ii) *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 such 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. Such terms must satisfy the requirements of paragraph (b) (10) through (12) of this section.

(12) *Other put option provisions*—(i) *Manner of exercise*. A put option is exercised by the holder notifying the employer in writing that the put option is being exercised.

(ii) *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.

(iii) *Price*. The price at which a put option must be exercisable is the value of the security, determined under § 54.4975–11(d)(5).

(iv) *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 excercised, 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 the put option are entirely repaid.

(v) *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.

(13) *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.

(14) *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 § 54.4975–11 will be exempt as of the time of such

loan if the plan is amended retroactively under section 401(b) or § 54.4975–11(a)(4).

(15) *Special rules for certain loans*—(i) *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 the agreement on that date) is exempt for the entire period of the loan if it otherwise satisfies the provisions of this paragraph (b) for such period, even though it does not satisfy the following provisions of this section: the last sentence of paragraph (b) (4) and all of paragraph (b) (5), (6), (8) (i) and (ii), and (9) through (13), inclusive.

(ii) *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 the agreement on that date) is exempt for the entire period of the loan if it otherwise satisfies the provisions of this paragraph (b) for such period even though it does not satisfy the following provisions of this section: paragraph (b) (6) and (9) and the three additional rules listed in paragraph (b) (8) (ii).

(iii) *Release rule.* Notwithstanding paragraph (b) (15) (i) and (ii) 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 (b) (8) of this section.

(iv) *Default rule.* Notwithstanding paragraph (b) (15) (i) and (ii) of this section, a loan by a disqualified person other than a guarantor must meet the requirements of paragraph (b) (6) of this section. A loan will meet these requirements if it is retroactively amended before November 1, 1977 to meet these requirements.

(v) *Put option rule.* With respect to a security distributed before November 1, 1977, the put option provisions of paragraph (b) (10), (11), and (12) 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, 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.

(Sec. 4975 (e) (7), (88 Stat. 976; 26 U.S.C. 4975 (e) (7)))

[T.D. 7506, 42 FR 44391, Sept. 2, 1977]

§ 54.4975–9 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 4975(e)(3)(B) and this paragraph, only if:

(i) Such person renders advice to the plan 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; 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 stategy, 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 Employee Retirement Income Security Act of 1974 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 *disqualified person* (as set forth in section 4975(e)(2)) 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 4975(e)(3), 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 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 Employee Retirement Income Security Act of 1974 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 *disqualified person* (as set forth in section 4975(e)(2)) 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 in section 4975(e)(6)) 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.

[T.D. 7386, 40 FR 50841, Oct. 31, 1975]

§ 54.4975–11 "ESOP" requirements.

(a) *In general*—(1) *Type of plan.* To be an ''ESOP'' (employee stock ownership plan), a plan described in section 4975(e)(7)(A) must meet the requirements of this section. See section 4975(e)(7)(B).

(2) *Designation as ESOP.* To be an ESOP, a plan must be formally designated as such in the plan document.

(3) *Continuing loan provisions under plan*—(i) *Creation of protections and rights.* The terms of an ESOP must formally provide participants with certain protections and rights with respect to plan assets acquired with the proceeds of an exempt loan. These protections and rights are those referred to in the third sentence of § 54.4975–7(b)(4), relating to put, call, or other options and to buy-sell or similar arrangements, and in § 54.4975–7(b) (10), (11), and (12), relating to put options.

(ii) *''Nonterminable'' protections and rights.* The terms of an ESOP must also formally provide that these protections and rights are nonterminable. Thus, if a plan holds or has distributed securities acquired with the proceeds of an exempt loan and either the loan is repaid or the plan ceases to be an ESOP, these protections and rights must continue to exist under the terms of the plan. However, the protections and rights will not fail to be nonterminable merely because they are not exercisable under § 54.4975–7(b) (11) and (12)(ii). For example, if, after a plan ceases to be an ESOP, securities acquired with the proceeds of an exempt loan cease to be publicly traded, the 15-month period prescribed by § 54.4975–7(b)(11) includes the time when the securities are publicly traded.

(iii) *No incorporation by reference of protections and rights.* The formal requirements of paragraph (a)(3) (i) and (ii) of this section must be set forth in the plan. Mere reference to the third sentence of § 54.4975–7(b)(4) and to the provisions of § 54.4975–7(b) (10), (11), and (12) is not sufficient.

(iv) *Certain remedial amendments.* Notwithstanding the limits under paragraph (a) (4) and (10) of this section on the retroactive effect of plan amendments, a remedial plan amendment adopted before December 31, 1979, to meet the requirements of paragraph (a)(3) (i) and (ii) of this section is retroactively effective as of the later of the date on which the plan was designated as an ESOP or November 1, 1977.

(4) *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 time in paragraph (a)(4)(i) of this section; or

(iii) A later date approved by the district director.

(5) *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.

(6) *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 Employee Retirement Income Security Act of 1974 (ERISA) (88 Stat. 877), relating to fiduciary duties, and section 401(a) of the Code, relating to requirements for

plans established for the exclusive benefit of employees, applying 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 ERISA.

(7) *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 § 54.4975–7(b) (10), (11) and (12). 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.

(ii) *Integrated plans*. A plan designated as an ESOP after November 1, 1977, must not be integrated directly or indirectly with contributions or benefits under title II of the Social Security Act or any other State or Federal law. ESOP's established and integrated before such date may remain integrated. However, such plans must not be amended to increase the integration level or the integration percentage. Such plans may in operation continue to increase the level of integration if under the plan such increase is limited by reference to a criterion existing apart from the plan.

(8) *Effect of certain ESOP provisions on section 401(a) status*—(i) *Exempt loan requirements*. An ESOP will not fail to meet the requirements of section 401(a)(2) merely because it gives plan assets as collateral for an exempt loan under § 54.4975–7(b)(5) or uses plan assets under § 54.4975–7(b)(6) to repay and exempt loan in the event of default.

(ii) *Individual annual contribution limitation*. An ESOP will not fail to meet the requirements of section 401(a)(16) merely because annual additions under section 415(c) are calculated with respect to employer contributions used to repay an exempt loan rather than with respect to securities allocated to participants.

(iii) *Income pass-through*. An ESOP will not fail to meet the requirements of section 401(a) merely because it provides for the current payment of income under paragraph (f)(3) of this section.

(9) *Transitional rules for ESOP's established before November 1, 1977*. A plan established before November 1, 1977 that otherwise satisfies the provisions of this section constitutes an ESOP if it is amended by December 31, 1977, to comply from November 1, 1977 with this section even though before November 1, 1977 the plan did not satisfy paragraphs (c) and (d) (2), (4), and (5) of this section.

(10) *Additional transitional rules*. Notwithstanding paragraph (a)(9) of this section, a plan established before November 1, 1977, that otherwise satisfies the provisions of this section constitutes an ESOP if by December 31, 1977, it is amended to comply from November 1, 1977, with this section even though before such date the plan did not satisfy the following provisions of this section:

(i) Paragraph (a) (3) and (8) (iii);

(ii) The last sentence of paragraph (d)(3); and

(iii) Paragraph (f)(3).

(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 401a with respect to those investments.

(c) *Suspense account*. All assets acquired by an ESOP with the proceeds of an exempt loan under section 4975(d)(3) must be added to and maintained in a suspense account. They are to be withdrawn from the suspense account by applying § 54.4975–7(b) (8) and (15) as if all securities in the suspense account were encumbered. Such assets acquired before November 1, 1977, must be withdrawn by applying § 54.4975–7(b)(8) or the provision of the loan that controls release from encumbrance. Assets in such suspense accounts are assets of the ESOP. Thus, for example, such assets are subject to section 401(a)(2).

(d) *Allocations to accounts of participants*—(1) *In general.* Except as provided in this section, amounts contributed to an ESOP must be allocated as provided under § 1.401–1(b)(ii) and (iii) of this chapter, and securities acquired by an ESOP must be accounted for as provided under § 1.402(a)–1(b)(2)(ii) of this chapter.

(2) *Assets withdrawn from suspense account.* As of the end of each plan year, the ESOP must consistently allocate to the participants' accounts non-monetary units representing participants' interests in assets withdrawn from the suspense account.

(3) *Income.* Income with respect to securities acquired with the proceeds of an exempt loan must be allocated as income of the plan except to the extent that the ESOP provides for the use of income from such securities to repay the loan. Certain income may be distributed currently under paragraph (f)(3) of this section.

(4) *Forfeitures.* If a portion of a participant's account is forfeited, qualifying employer securities allocated under paragraph (d)(2) of this section must be forfeited only after other assets. If interests in more than one class of qualifying employer securities have been allocated to the participant's account, the participant must be treated as forfeiting the same proportion of each such class.

(5) *Valuation.* For purposes of § 54.4975–7(b) (9) and (12) and this section, valuations must be made in good faith and based on all relevant factors for determining the fair market value of securities. In the case of a transaction between a plan and a disqualified person, value must be determined as of the date of the transaction. For all other purposes under this subparagraph (5), value must be determined as of the most recent valuation date under the plan. An independent appraisal will not in itself be a good faith determination of value in the case of a transaction between a plan and a disqualified person. However, in other cases, a determination of fair market value based on at least an annual appraisal independently arrived at by a person who customarily makes such appraisals and who is independent of any party to a transaction under § 54.4975–7(b) (9) and (12) will be deemed to be a good faith determination of value.

(e) *Multiple plans*—(1) *General rule.* An ESOP may not be considered together with another plan for purposes of applying section 401(a) (4) and (5) or section 410(b) unless:

(i) The ESOP and such other plan exist on November 1, 1977, or

(ii) Paragraph (e)(2) of this section is satisfied.

(2) *Special rule for combined ESOP's.* Two or more ESOP's, one or more of which does not exist on November 1, 1977, may be considered together for purposes of applying section 401(a) (4) and (5) or section 410(b) only if the proportion of qualifying employer securities to total plan assets is substantially the same for each ESOP and:

(i) The qualifying employer securities held by all ESOP's are all of the same class; or

(ii) The ratios of each class held to all such securities held is substantially the same for each plan.

(3) *Amended coverage, contribution, or benefit structure.* For purposes of paragraph (e)(1)(i) of this section, if the coverage, contribution, or benefit structure of a plan that exists on November 1, 1977 is amended after that date, as of the effective date of the amendment, the plan is no longer considered to be a plan that exists on November 1, 1977.

(f) *Distribution*—(1) *In general.* Except as provided in paragraph (f) (2) and (3) of this section, with respect to distributions, a portion of an ESOP consisting of stock bonus plan or a money purchase pension plan is not to be distinguished from other such plans under section 401(a). Thus, for example, benefits distributable from the portion of an ESOP consisting of a stock bonus plan are distributable only in stock of the employer. Also, benefits distributable from the money-purchase portion of the ESOP may be, but are not required to be, distributable in qualifying employer securities.

(2) *Exempt loan proceeds.* If securities acquired with the proceeds of an exempt loan available for distribution consist of more than one class, a distributee must receive substantially the same proportion of each such class.

However, as indicated in paragraph (f)(1) of this section, benefits distributable from the portion of an ESOP consisting of a stock bonus plan are distributable only in stock of the employer.

(3) *Income*. Income paid with respect to qualifying employer securities acquired by an ESOP in taxable years beginning after December 31, 1974, may be distributed at any time after receipt by the plan to participants on whose behalf such securities have been allocated. However, under an ESOP that is a stock bonus plan, income held by the plan for a 2-year period or longer must be distributed under the general rules described in paragraph (f)(1) of this section. (See the last sentence of section 803(h), Tax Reform Act of 1976.)

(Sec. 4975(e)(7), (88 Stat. 976; 26 U.S.C. 4975(e)(7)))

[T.D. 7506, 42 FR 44393, Sept. 2, 1977, as amended by T.D. 7571, 44 FR 1978, Jan. 9, 1979]

§ 54.4975–12 Definition of the term "qualifying employer security".

(a) *In general*. For purposes of section 4975(e)(8) and this section, the term ''qualifying employer security'' means an employer security which is:

(1) Stock or otherwise an equity security, or

(2) A bond, debenture, note, or certificate or other evidence of indebtedness which is described in paragraphs (1), (2), and (3) of section 503(e).

(b) *Special rule*. In determining whether a bond, debenture, note, or certificate or other evidence of indebtedness is described in paragraphs (1), (2), and (3) of section 503(e), any organization described in section 401(a) shall be treated as an organization subject to the provisions of section 503.

(Sec. 4975(e)(7) (88 Stat. 976; 26 U.S.C. 4975(e)(7)))

[T.D. 7506, 42 FR 44394, Sept. 2, 1977]

§ 54.4975–14 Election to pay an excise tax for certain pre-1975 prohibited transactions.

(a) *In general*. Section 2003(c)(1)(B) of the Employee Retirement Income Security Act of 1974 (88 Stat. 978) provides an election to pay an excise tax by certain persons involved prior to 1975 in prohibited transactions within the meaning of section 503 (b) or (g).

(b) *Effect of election*. If a valid election is made under this section with respect to a particular transaction, any loss of exemption under section 501(a) because of a prohibited transaction within the meaning of section 503 (b) or (g) shall not apply. Instead, the person who made the election referred to in this section shall be subject to the taxes which would have been imposed by section 4975 (a) or (b) as though section 4975 had imposed a tax in respect of the transaction. (However, section 4975(f)(1), relating to joint and several liability, shall not apply to any person who has not made an election under this section, and interest for late payment of tax shall not begin to accrue until after the date of the election.) Such an election is irrevocable. However, the making of the election does not affect the application of section 6501 for purposes of assessment and collection of tax and section 6511 for purposes of filing a claim for credit or refund with respect to taxpayers and to taxable years of taxpayers whose tax liability is or may be affected by reason of the nonapplication of a denial of exempt status.

(c) *Method of election*. A person shall make the election referred to in this section by filing the form issued for such purpose by the Internal Revenue Service, including therein the information required by such form and the instructions issued with respect thereto, and by paying the tax which the taxpayer indicates is due at the time the return is filed. To be valid the election must be made prior to the later of December 6, 1976, or 120 days after the date of notification referred to in § 1.503(a)–1(b) of this chapter (Income Tax Regulations), relating to loss of exemption for certain prohibited transactions. If there has been no notification of loss of exemption, the election may be made at any time. However, these limitations do not preclude an agreement between the disqualified person and the district director to extend the time within which the election is permitted.

(d) *Computation of section 4975 excise tax*. To the extent applicable, and solely for purposes associated with the

payment of a section 4975 excise tax under the election referred to in this section, § 53.4941(e)–1 of this chapter (Foundation Excise Tax Regulations) is controlling.

(Sec. 2003(c)(1)(B) of the Employee Retirement Income Security Act of 1974 (88 Stat. 978))

[T.D. 7489, 42 FR 27882, June 1, 1977]

§ 54.4975–15 Other transitional rules.

(a)–(c) [Reserved]

(d) *Provision of certain services until June 30, 1977*—(1) *In general.* Section 2003(c)(2)(D) of the Employee Retirement Income Security Act of 1974 (the Act) (88 Stat. 979) provides that section 4975 shall not apply to the provision of services before June 30, 1977, between a plan and a disqualified person if the three requirements contained in section 2003(c)(2)(D) of the Act are met. The first requirement is that such services must be provided either (in) under a binding contract in effect on July 1, 1974 (or pursuant to a renewal or modification of such contract); or (ii) by a disqualified person who ordinarily and customarily furnished such services on June 30, 1974. The second requirement is that the services be provided on terms that remain at least as favorable to the plan as an arm's-length transaction with an unrelated party would be.

For this purpose, such services are provided on terms that remain at least as favorable to the plan as an arms-length transaction with an unrelated party would be if, at the time of execution (or renewal) of such binding contract, the contract (or renewal) is on terms at least as favorable to the plan as an arm's-length transaction with an unrelated party would be. However, if in a normal commercial setting an unrelated party in the position of the plan could be expected to insist upon a renegotiation or termination of a binding contract, the plan must so act. Thus, for example, if a disqualified person provides services to a plan on a month-to-month basis, and a party in the position of the plan could be expected to renegotiate the price paid under such contract because of a decline in the fair market value of such services, the plan must so act in order to avoid participation in a prohibited transaction. The third requirement is that the provision of services must not be, or have been, at the time of such provision a prohibited transaction within the meaning of section 503(b) or the corresponding provisions of prior law. If these three requirements are met, section 4975 will apply neither to services provided before June 30, 1977 (both to customers to whom such services were being provided on June 30, 1974, and to new customers) nor to the receipt of compensation therefor. Thus, if these three requirements are met, section 4975 will not apply until June 30, 1977, to the provision of services to a plan by a disqualified person (including a fiduciary) even if such services could not be furnished pursuant to the exemption provisions of sections 4975(d)(2) or (6) and § 54.4975–6. For example, if the three requirements of section 2003(c)(2)(D) of the Act are met, a person serving as fiduciary to a plan who already receives full-time pay from an employer or an association of employers, whose employees are participants in such plan, or from an employee organization whose members are participants in such plan, may continue to receive reasonable compensation from the plan for services rendered to the plan before June 30, 1977. Similarly, until June 30, 1977, a plan consultant who may be a fiduciary because of the nature of the consultative and administrative services being provided may, if these three requirements are met, continue to cause the sale of insurance to the plan and continue to receive commissions for such sales from the insurance company writing the policy. Further, if the three requirements of section 2003 (c)(2)(D) of the Act are met, a securities broker dealer who renders investment advice to a plan for a fee, thereby becoming a fiduciary may furnish other services to the plan, such as brokerage services, and receives compensation therefor. Also, if a registered representative of such a broker-dealer were a fiduciary, the registered representative may receive compensation, including commissions, for brokerage services performed before June 30, 1977.

(2) *Persons deemed to be June 30, 1974, service providers.* A disqualified person with respect to a plan which did not,

on June 30, 1974, ordinarily and customarily furnish a particular service, will nevertheless be considered to have ordinarily and customarily furnished such service on June 30, 1974, for purposes of this section and section 2003(c)(2)(D) of the Act, if either of the following conditions are met:

(i) At least 50 percent of the outstanding beneficial interests of such disqualified person are owned directly or through one or more intermediaries by the same person or persons who owned, directly or through one or more intermediaries, at least 50 percent of the outstanding beneficial interests of a person who ordinarily and customarily furnished such service on June 30, 1974; or

(ii) Control, or the power to exercise a controlling influence over the management and policies of such disqualified person is possessed, directly or through one or more intermediaries, by the same person or persons who possessed directly or through one or more intermediaries control, or the power to exercise a controlling influence over the management and policies of a person who ordinarily and customarily furnished such service on June 30, 1974. For purposes of this paragraph (d)(2) a person shall be deemed to be an ''intermediary'' of another person if at least 50 percent of the outstanding beneficial interests of such person are owned by such other person, directly or indirectly, or if such other person controls or has the power to exercise a controlling influence over the management and policies of such person.

(3) *Examples.* The principals of § 54.4975–15(d)(2) may be illustrated by the following examples.

Example 1. A owns 50 percent of the outstanding beneficial interests of ABC Partnership which ordinarily and customarily furnished certain services on June 30, 1974. On July 2, 1974, ABC Partnership was incorporated into ABC Corporation with one class of stock outstanding. A owns 50 percent of the shares of such stock. ABC Corporation furnishes the same services that were furnished by ABC Partnership on June 30, 1974. ABC Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example 2. A and B together own 100 percent of the beneficial interests of AB Partnership, which ordinarily and customarily furnished certain services on June 30, 1974. On September 1, 1974, AB Partnership was incorporated into AB Corporation with one class of stock outstanding. A and B each own 20 percent of such outstanding class of stock and together have control over the management and policies of AB Corporation. AB Corporation furnishes the same services that were furnished by AB Partnership on June 30, 1974. AB Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example 3. On June 30, 1974, M Corporation was ordinarily and customarily furnishing certain services. On that date, X, Y and Z together owned 50 percent of all classes of the outstanding shares of M Corporation. On January 28, 1975, all of the shareholders of M Corporation exchanged their shares in M Corporation for shares of a new N Corporation. As a result of that exchange, X, Y and Z together own 50 percent of the common stock of N Corporation, the only class of N Corporation stock outstanding after the exchange. N Corporation furnishes the services formerly furnished by M Corporation. N Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example 4. I Corporation ordinarily and customarily furnished certain services on June 30, 1974. On November 3, 1975, I Corporation organizes a wholly owned subsidiary, S Corporation, which furnishes the same services ordinarily and customarily furnished by I Corporation on June 30, 1974. S Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

Example 5. X Corporation, wholly-owned and controlled by A, ordinarily and customarily furnished certain services on June 30, 1974. Y Corporation did not perform such services on that date. On January 2, 1976, X Corporation is merged into Y Corporation and although A received less than 50 percent of the total outstanding shares of Y Corporation, after such merger A has control over the management and policies of Y Corporation. Y Corporation furnishes the same services that were formerly furnished by X Corporation. Y Corporation will be deemed to have ordinarily and customarily furnished such services on June 30, 1974, for purposes of section 2003(c)(2)(D) of the Act.

[T.D. 7491, 42 FR 32388, June 24, 1977]

§ 54.4976–1T Questions and answers relating to taxes with respect to welfare benefit funds (temporary).

Q–1: What does section 4976 provide?

A–1: Section 4976 imposes a tax on employers who provide disqualified

benefits through a welfare benefit fund. The tax imposed is equal to 100 percent of the disqualified benefit.

Q–2: What constitutes a disqualified benefit?

A–2: A disqualified benefit is (a) any post-retirement medical or life insurance benefit provided with respect to a key employee (as defined in section 419A(d)(3)) through a welfare benefit fund if a separate account is required to be established for such employee under section 419A(d) and the cost for such coverage is not charged against or paid from such separate account; (b) any post-retirement medical or life insurance benefit provided through a welfare benefit fund with respect to an individual in whose favor discrimination is prohibited unless the plan of which the fund is a part meets the requirements of section 505(b) with respect to that benefit; and (c) any portion of the fund which reverts to the benefit of the employer. A post-retirement medical or life insurance benefit provided with respect to a key employee will not constitute a disqualified benefit even though such benefit is not provided through a separate account if the cost of such benefit is paid by the employer in the taxable year in which the benefit is provided and there is not (and there is not required to be) a separate account with an outstanding credit balance maintained for the key employee.

Q–3: What is the effective date of section 4976?

A–3: (a) Generally, section 4976 applies to disqualified benefits provided by a welfare benefit fund after December 31, 1985. However, a disqualified benefit, as defined in section 4976(b)(1) or (2), is not subject to section 4976(a) if it is provided from ''existing reserves for post-retirement medical or life insurance benefits'' that are within the transition rule set forth in section 512(a)(3)(E)(iii) and Q&A–4 of § 1.512(a)–5T (or would be if such transition rule applied to such welfare benefit fund). For example, if a welfare benefit fund in existence on July 18, 1984, provides an individual in whose favor discrimination is prohibited with a post-retirement life insurance benefit after December 31, 1985, that does not meet the requirements of section 505(b) and if the welfare benefit fund received no contributions after July 18, 1984, then the disqualified benefit provided by the fund is not subject to section 4976(a)

(b) A welfare benefit fund will be able to avoid the application of section 4976(b)(1) and (2) if the employer withdraws from such fund, before April 7, 1986, any amounts that are not attributable to ''existing reserves for post-retirement medical or life insurance benefits'' because they were neither actually set aside nor treated as actually set aside under Q&A–4 of § 1.512(a)–5T, on July 18, 1984. The employer making such a withdrawal must include the amount in income for the first taxable year ending after July 18, 1984, or, to the extent that the withdrawn amount is attributable to the following taxable year, for such following taxable year. Such a withdrawal will not be treated as an impermissible distribution or reversion under section 501(c)(9), and will not be treated as a disqualified benefit under section 4976(b)(3). Of course, to the extent that the welfare benefit fund contains amounts that are attributable to ''existing reserves'' but are not within the transition rule set forth in Q&A–4 of § 1.512(a)–5T (as applied to welfare benefit funds), for example, because such amounts exceed the amounts that could have been accumulated under the principles set forth in Revenue Rulings 69–382, 1969–2 C.B. 28; 69–478, 1969–2 C.B. 29; and 73–599, 1973–2 C.B. 40, the fund will not be able to avoid the application of section 4976(b)(1) and (2) under this paragraph.

(c) In the case of a plan which is maintained pursuant to one or more collective bargaining agreements (1) between employee representatives and one or more employers and (2) which are in effect on July 1, 1985 (or ratified on or before that date), the provision does not apply to disqualified benefits provided in years beginning before the termination of the last of the collective bargaining agreements pursuant to which the plan is maintained (determined without regard to any extension of the contract agreed to after July 1, 1985). For purposes of the preceding sentence, any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added under section

511 of the Tax Reform Act 1984 (*i.e.*, requirements under sections 419, 419A, 512(a)(3)(E), and 4976) shall not be treated as a termination of such collective bargaining agreement.

[T.D. 8073, 51 FR 4336, Feb. 4, 1986]

§ 54.4977–1T Questions and answers relating to the election concerning lines of business in existence on January 1, 1984 (temporary).

The following questions and answers relate to the election by employers under section 4977 of the Internal Revenue Code of 1954, as added by section 531(e)(1) of the Tax Reform Act of 1984 (98 Stat. 886), to treat all employees of any line of business in existence on January 1, 1984, as employees of one of those lines of business for purposes of section 132(a) (1) and (2):

Q–1: What does section 4977 provide with respect to the exclusion from gross income of certain fringe benefits?

A–1: In general, section 4977 provides an elective grandfather rule that allows an employer under certain circumstances to treat employees of all lines of business which were in existence on January 1, 1984, as employees of one of those lines of business for purposes of section 132(a) (1) and (2), but not for purposes of section 132(g)(2).

Q–2: Under what circumstances does the elective grandfather rule of section 4977 apply?

A–2: If:

(a) An election under section 4977 is in effect with respect to an employer for any calendar year, and

(b) On and after January 1, 1984, at least 85 percent of the employees of the employer in all of its lines of business which existed on January 1, 1984, were entitled to employee discounts or services provided by the employer in one line of business,

then all employees of any line of business of the employer which was in existence on January 1, 1984, are treated, for purposes of section 132(a) (1) and (2) (but not for purposes of section 132(g)(2)) as employees of the one line of business referred to in (b) of this Q/A–2.

Q–3: How does an employer make the election provided for in section 4977?

A–3: An employer must file a statement with the director of the service center with which the employer's tax returns are filed. The statement must indicate that the employer is electing to apply the provisions of section 4977 to one or more of the employer's lines of business and must contain the following information:

(a) The employer's name, address, and taxpayer identification number;

(b) A description of all of the employer's lines of business in existence on January 1, 1984; and

(c) For each lines of business which is to have as an employee for purposes of section 132(a) (1) and (2) an individual but for the election under section 4977 would not be treated as an employee for purposes of section 132(a) (1) and (2):

(1) A description of the no-additional-cost service or qualified employee discount (including, with respect to discounts, the percentage discount) to be offered to employees pursuant to section 4977 in such line of business, and

(2) With respect to employees in all of the employer's lines of business in existence on January 1, 1984, the number of such employees and the number entitled to the described fringe benefit. Such numbers may be determined as of a date which does not precede the date the election is filed by more than 30 days.

Q–4: In order to make a timely section 4977 election, when must an employer file the election statement?

A–4: Except as otherwise provided in the second sentence of this answer, the employer must file the election statement before the end of the calendar year preceding the year for which the election is to apply. For calendar year 1985, however, the employer has until March 31, 1985, to file the election statement. However, the Commissioner may, in his discretion, extend the March 31, 1985 deadline to a later date.

Q–5: Does section 4977 apply to all calendar years following the calendar year in which the election is made?

A–5: Yes, unless the employer revokes the election.

Q–6: When is a revocation effective?

A–6: A revocation is effective with respect to the calendar year following the calendar year in which it is filed.

Q–7: If an employer does not make a timely section 4977 election with respect to 1985, will the employer be entitled to make an election with respect to any subsequent year?

A–7: No.

Q–8: If an employer revokes a section 4977 election, is the employer entitled to elect the application of section 4977 for subsequent years?

A–8: No.

[T.D. 8004, 50 FR 758, Jan. 7, 1985]

§ 54.4978–1T Questions and answers relating to the tax on certain dispositions by employee stock ownership plans and certain cooperatives (temporary).

Q–1: What does section 4978 provide?

A–1: Section 4978 imposes a tax (as determined under section 4978(b) and Q&A–2 of this section) on the amount realized on the disposition of any qualified securities, if:

(a) An employee stock ownership plan or eligible worker-owned cooperative acquires any qualified securities in a sale to which section 1042 applies;

(b) Such plan or cooperative disposes of any qualified securities during the 3-year period after the date on which any qualified securities were acquired in the sale to which section 1042 applies; and

(c) Either (1) the percentage of the total outstanding shares of the class of employer securities of which the disposed qualified securities are a part held by such plan or cooperative after such disposition is less than the percentage of the total outstanding shares of such class of employer securities held immediately after the sale to which section 1042 applies, or (2) the value of the employer securities held by such plan or cooperative immediately after such disposition is less than 30 percent of the total value of all employer securities outstanding at that time. For purposes of this section, the following terms have the same meanings given to such terms by the identified provisions: ''employee stock ownership plan'' (section 4975(e)(7)); ''qualified securities'' (section 1042(b)(1)); ''eligible worker-owned cooperative'' (section 1042(b)(2)); ''employer securities'' (section 409(l)). For purposes of determining what constitutes a disposition to which section 4978 applies, see Q&A–3 of this section.

Q–2: What is the amount of tax imposed under section 4978?

A–2: Section 4978 imposes a tax of 10 percent of the amount realized on the disposition of qualified securities. The amount realized that is subject to tax under section 4978 shall not exceed that portion of the amount realized that is allocable to qualified securities acquired within the 3-year period prior to the date of disposition and to which section 1042 applied (''restricted qualified securities''). In determining the amount realized (except as otherwise provided in Q&A–3 of this section), any disposition of employer securities with respect to which the condition contained in provision (c) of Q&A–1 is met shall be treated, first, as a disposition of restricted qualified securities (on a first in, first out basis) and, thereafter, as a disposition of any other employer securities. Thus, for example, if a plan disposes of more employer securities than the number of restricted qualified securities held by the plan at that time and immediately after such disposition the value of the employer securities held by the plan is less than 30 percent of the total value of all outstanding employer securities, the portion of the total amount realized that is allocable to restricted qualified securities subject to tax under section 4978 is determined by multiplying the total amount realized on the disposition by a fraction, the numerator of which is the total value of restricted qualified securities included in the disposition and the denominator of which is the total value of employer securities in the disposition.

Q–3: What constitutes a ''disposition'' under section 4978?

A–3: (a) Under section 4978, the term ''disposition'' includes any sale, exchange, or distribution. However, in the case of any exchange of qualified securities for stock of another corporation in any reorganization described in section 368(a)(1), such exchange shall not be treated as a disposition for purposes of section 4978.

(b) Section 4978 shall not apply to any disposition of qualified securites which is made by reason of:

(1) The death of the employee;

(2) The retirement of the employee after the employee has attained 59½ years of age;

(3) The disability of the employee (within the meaning of section 72(m)(5)); or

(4) The separation of the employee from service for any period which results in a 1-year break in service (within the meaning of section 411(a)(6)(A)).

Any disposition of employer securities within this paragraph and any disposition of employer securities with respect to which the condition contained in provision (c) of Q&A–1 of this section is not met shall be treated, first, as a disposition of securities that are not restricted qualified securities and, thereafter, as a disposition of restricted qualified securities (on a first-in, first-out basis).

(c) If restricted qualified securities held by an employee stock ownership plan or eligible worker-owned cooperative no longer meet the definition of qualified securities (''old restricted qualified securities'') as a result of a transaction changing (1) the status of a corporation as an employer, or as a member of a controlled group of corporations including the employer, or (2) the existence of employer securities of the type described in section 409(l)(1), the disposition of such securities shall not be treated as a disposition of restricted qualified securites to which the tax under section 4978 is imposed if, within 90 days after such disposition, securities meeting the requirements of section 409(l) (''new restricted qualified securities'') that are of equal value to the old restricted qualfied securities (at the time of the disposition of the old restricted qualified securities) are substituted for such old restricted qualified securities. However, for purposes of determining the tax imposed under section 4978, old restricted qualified securities shall not be treated as if they retained their status as restricted qualified securities and new restricted qualified securities derived from the disposition of old restricted qualified securities pursuant to the preceding sentence shall be treated as restricted qualified securities for the remaining portion of the period during which the disposition of the old restricted qualified securities would have been subject to tax under section 4978.

Q–4: To whom does the tax under section 4978 apply?

A–4: The tax under section 4978 is imposed on the domestic corporation (or corporations) or the eligible worker-owned cooperative that made the written statement of consent as described in section 1042(a)(2)(B) and Q&A–2 of § 1.1042–1T with respect to the disposition of the restricted qualified securities.

Q–5: When does section 4978, as enacted by the Tax Reform Act of 1984, become effective?

A–5: Section 4978 applies to the disposition of qualified securities acquired in a sale to which section 1042 applies. See Q&A–6 of § 1.1042–1T for the effective date of section 1042.

[T.D. 8073, 51 FR 4336, Feb. 4, 1986]

§ 54.4979–0 Excise tax on certain excess contributions and excess aggregate contributions; table of contents.

This section contains the captions that appear in § 54.4979.

§ 54.4979–1 Excise tax on certain excess contributions and excess aggregate contributions.

(a) In general.
(1) General rule.
(2) Liability for tax.
(3) Due date and form for payment of tax.
(4) Special rule for simplified employee pensions.
(b) Definitions.
(1) Excess aggregate contributions.
(2) Excess contributions.
(3) Plan.
(c) No tax when excess distributed within 2½ months of close of year or additional employer contributions made.
(1) General rule.
(2) Tax treatment of distributions.
(3) Income.
(4) Example.
(d) Effective date.
(1) General rule.
(2) Section 403(b) annuity contracts.
(3) Collectively bargained plans and plans of state or local governments.
(4) Plan years beginning before January 1, 1992.

[T.D. 8357, 56 FR 40550, Aug. 15, 1991; 57 FR 10290, Mar. 25, 1992, as amended by T.D. 8581, 59 FR 66181, Dec. 23, 1994]

§ 54.4979–1 Excise tax on certain excess contributions and excess aggregate contributions.

(a) *In general*—(1) *General rule.* In the case of any plan (as defined in paragraph (b)(3) of this section), there is imposed a tax for the employer's taxable year equal to 10 percent of the sum of:

(i) Any excess contributions under a plan for the plan year ending in the taxable year; and

(ii) Any excess aggregate contributions under the plan for the plan year ending in the taxable year.

(2) *Liability for tax.* The tax imposed by paragraph (a)(1) of this section is to be paid by the employer. In the case of a collectively bargained plan to which section 413(b) applies, all employers who are parties to the collective bargaining agreement and whose employees are participants in the plan are jointly and severally liable for the tax.

(3) *Due date and form for payment of tax*—(i) The tax described in paragraph (a)(1) of this section is due on the last day of the 15th month after the close of the plan year to which the excess contributions or excess aggregate contributions relate.

(ii) An employer that owes the tax described in paragraph (a)(1) of this section must file the form prescribed by the Commissioner for the payment of the tax.

(4) *Special rule for simplified employee pensions*—(i) An employer that maintains a simplified employee pension (SEP) as defined in section 408(k) that accepts elective contributions is exempted from the tax of section 4979 and paragraph (a)(1) of this section if it notifies its employees of the fact and tax consequences of excess contributions within 2½ months following the plan year for which excess contributions are made. The notification must meet the standards of paragraph (a)(4)(ii) of this section.

(ii) The employer's notification to each affected employee of the excess SEP contributions must specifically state, in a manner calculated to be understood by the average plan participant: the amount of the excess contributions attributable to that employee's elective deferrals; the calendar year for which the excess contributions were made; that the excess contributions are includible in the affected employee's gross income for the specified calendar year; and that failure to withdraw the excess contributions and income attributable thereto by the due date (plus extensions) for filing the affected employee's tax return for the preceding calendar year may result in significant penalties.

(iii) If an employer does not notify its employees by the last day of the 12-month period following the year of excess SEP contributions, the SEP will no longer be considered to meet the requirements of section 408(k)(6).

(b) *Definitions.* The following is a list of terms and definitions to be used for purposes of section 4979 and this section:

(1) *Excess aggregate contributions.* The term ''excess aggregate contribution'' has the meaning set forth in § 1.401(m)–5 of this chapter. For purposes of determining excess aggregate contributions under an annuity contract described in section 403(b), the contract is treated as a plan described in section 401(a).

(2) *Excess contributions.* The term ''excess contributions'' has the meaning set forth in sections 401(k)(8)(B), 408(k)(6)(C)(ii), and 501(c)(18). See, e.g., § 1.401(k)–6 of this chapter.

(3) *Plan.* The term ''plan'' means:

(i) A plan described in section 401(a) that includes a trust exempt from tax under section 501(a);

(ii) Any annuity plan described in section 403(a);

(iii) Any annuity contract described in section 403(b);

(iv) A simplified employee pension of an employer that satisfies the requirements of section 408(k); and

(v) A plan described in section 501(c)(18).

The term includes any plan that at any time has been determined by the Secretary to be one of the types of plans described in this paragraph (b)(3).

(c) *No tax when excess distributed within 2½ months of close of year or additional employer contributions made*—(1) *General rule.* No tax is imposed under this section on any excess contribution or excess aggregate contribution, as the case may be, to the extent the contribution (together with any income allocable thereto) is corrected before the

close of the first 2½ months of the following plan year (6 months in the case of a plan that includes an eligible automatic contribution arrangement within the meaning of section 414(w)). The extension to 6 months applies to a distribution of excess contributions or excess aggregate contributions for a plan year beginning on or after January 1, 2010, only where all the eligible NHCEs and eligible HCEs (both as defined in § 1.401(k)–6 of this Chapter) are covered employees under an eligible automatic contribution arrangement within the meaning of section 414(w) for the entire plan year (or the portion of the plan year that the eligible NHCEs and eligible HCEs are eligible employees under the plan)). Qualified nonelective contributions and qualified matching contributions taken into account under § 1.401(k)–2(a)(6) of this Chapter or qualified nonelective contributions or elective contributions taken into account under § 1.401(m)–2(a)(6) of this Chapter for a plan year may permit a plan to avoid excess contributions or excess aggregate contributions, respectively, even if made after the close of the 2½ month (or 6 month) period for distributing excess contributions or excess aggregate contributions without the excise tax. See § 1.401(k)–2(b)(1)(i) and (5)(i) of this Chapter for methods to avoid excess contributions, and § 1.401(m)–2(b)(1)(i) of the Chapter for methods to avoid excess aggregate contributions.

(2) *Tax treatment of distributions.* See § 1.401(k)–2(b)(3)(ii) and (2)(vi) of this chapter for rules for determining the tax consequences to a participant of a distribution or recharacterization of excess contributions and income allocable thereto, including a special rule for de minimis distributions. See § 1.401(m)–2(b)(2)(vi) of this chapter for rules for determining the tax consequences to a participant of a distribution of excess aggregate contributions and income allocable thereto.

(3) *Income.* See § 1.401(k)–2(b)(2)(iv) of this chapter for rules for determining income allocable to excess contributions. See § 1.401(m)–2(b)(2)(iv) of this chapter for rules for determining income allocable to excess aggregate contributions.

(4) *Example.* The provisions of this paragraph (c) are illustrated by the following example.

Example. (i) Employer X maintains Plan Y, a calendar year profit-sharing plan that includes a qualified cash or deferred arrangement. Under the plan, failure to satisfy the actual deferral percentage test may only be corrected by distributing the excess contributions or making qualified nonelective contributions (QNECs).

(ii) On December 31, 1990, X determines that Y does not satisfy the actual deferral percentage test for the 1990 plan year, and that excess contributions for the year equal $5,000. On March 1, 1991, Y distributes $2,000 of these excess contributions. On May 30, 1991, X distributes another $2,000 of excess contributions. On December 17, 1991, X contributes QNECs for certain nonhighly compensated employees, thereby eliminating the remainder of the excess contributions for 1990.

(iii) X has incurred a tax liability under section 4979 for 1990 equal to 10 percent of the excess contributions that were in the plan as of December 31, 1990. However, this tax is not imposed on the $2,000 distributed on March 1, 1991, or the amount corrected by QNECs. X must pay an excise tax of $200, 10 percent of the $2,000 of excess contributions distributed after March 15, 1991. This tax must be paid by March 31, 1992.

(d) *Effective date*—(1) *General rule.* Except as provided in paragraphs (d)(2) through (4), this section is effective for plan years beginning after December 31, 1986.

(2) *Section 403(b) annuity contracts.* In the case of an annuity contract under section 403(b), this section applies to plan years beginning after December 31, 1988.

(3) *Collectively bargained plans and plans of state or local governments.* For plan years beginning before January 1, 1993, the provisions of this section do not apply to a collectively bargained plan that automatically satisfies the requirements of section 410(b). See §§ 1.401(a)(4)–1(c)(5) and 1.410(b)–2(b)(7) of this chapter. In the case of a plan (including a collectively bargained plan) maintained by a state or local government, the provisions of this section do not apply for plan years beginning before the later of January 1, 1996, or 90 days after the opening of the first legislative session beginning on or after January 1, 1996, of the governing body with authority to amend the plan,

if that body does not meet continuously. For purposes of this paragraph (d)(3), the term *governing body with authority to amend the plan* means the legislature, board, commission, council, or other governing body with authority to amend the plan.

(4) *Plan years beginning before January 1, 1992.* For plan years beginning before January 1, 1992, a reasonable interpretation of the rules set forth in section 4979, as in effect during those years, may be relied upon in determining whether the excise tax is due for those years.

[T.D. 8357, 56 FR 40550, Aug. 15, 1991, as amended by T.D. 8581, 59 FR 66181, Dec. 23, 1994; T.D. 9169, 69 FR 78153, Dec. 29, 2004; T.D. 9447, 74 FR 8214, Feb. 24, 2009]

EDITORIAL NOTE: By T.D. 9169, 69 FR 78154, Dec. 29, 2005, § 54.4979–1 was amended in paragraph (c)(2); however, the amendment could not be incorporated due to inaccurate amendatory instruction.

§ 54.4980B–0 Table of contents.

This section contains first a list of the section headings and then a list of the questions in each section in §§ 54.4980B–1 through 54.4980B–10.

LIST OF SECTIONS

§ 54.4980B–1 COBRA in general.
§ 54.4980B–2 Plans that must comply.
§ 54.4980B–3 Qualified beneficiaries.
§ 54.4980B–4 Qualifying events.
§ 54.4980B–5 COBRA continuation coverage.
§ 54.4980B–6 Electing COBRA continuation coverage.
§ 54.4980B–7 Duration of COBRA continuation coverage.
§ 54.4980B–8 Paying for COBRA continuation coverage.
§ 54.4980B–9 Business reorganizations and employer withdrawals from multiemployer plans.
§ 54.4980B–10 Interaction of FMLA and COBRA.

LIST OF QUESTIONS

§ 54.4980B–1 COBRA in general.

Q–1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?
Q–2: What standard applies for topics not addressed in §§ 54.4980B–1 through 54.4980B–10?

§ 54.4980B–2 Plans that must comply.

Q–1: For purposes of section 4980B, what is a group health plan?
Q–2: For purposes of section 4980B, what is the employer?
Q–3: What is a multiemployer plan?
Q–4: What group health plans are subject to COBRA?
Q–5: What is a small-employer plan?
Q–6: How is the number of group health plans that an employer or employee organization maintains determined?
Q–7: What is the plan year?
Q–8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?
Q–9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?
Q–10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?
Q–11: If a person is liable for the excise tax under section 4980B, what form must the person file and what is the due date for the filing and payment of the excise tax?

§ 54.4980B–3 Qualified beneficiaries.

Q–1: Who is a qualified beneficiary?
Q–2: Who is an employee and who is a covered employee?
Q–3: Who are the similarly situated nonCOBRA beneficiaries?

§ 54.4980B–4 Qualifying events.

Q–1: What is a qualifying event?
Q–2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

§ 54.4980B–5 COBRA continuation coverage.

Q–1: What is COBRA continuation coverage?
Q–2: What deductibles apply if COBRA continuation coverage is elected?
Q–3: How do a plan's limits apply to COBRA continuation coverage?
Q–4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?
Q–5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

§ 54.4980B–6 Electing COBRA continuation coverage.

Q–1: What is the election period and how long must it last?
Q–2: Is a covered employee or qualified beneficiary responsible for informing the plan administrator of the occurrence of a qualifying event?

Q–3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?
Q–4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?
Q–5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?
Q–6: Can each qualified beneficiary make an independent election under COBRA?

§ 54.4980B–7 Duration of COBRA continuation coverage.

Q–1: How long must COBRA continuation coverage be made available to a qualified beneficiary?
Q–2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?
Q–3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?
Q–4: When does the maximum coverage period end?
Q–5: How does a qualified beneficiary become entitled to a disability extension?
Q–6: Under what circumstances can the maximum coverage period be expanded?
Q–7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?
Q–8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

§ 54.4980B–8 Paying for COBRA continuation coverage.

Q–1: Can a group health plan require payment for COBRA continuation coverage?
Q–2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?
Q–3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?
Q–4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?
Q–5: What is timely payment for COBRA continuation coverage?

§ 54.4980B–9 Business reorganizations and employer withdrawals from multiemployer plans.

Q–1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?
Q–2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?
Q–3: In the case of an asset sale, what are the selling group and the buying group?
Q–4: Who is an M&A qualified beneficiary?
Q–5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?
Q–6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?
Q–7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?
Q–8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?
Q–9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?
Q–10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

§ 54.4980B–10 Interaction of FMLA and COBRA.

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?
Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it

occur, and how is the maximum coverage period measured?

Q–3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

Q–4: Is the application of the rules in Q&A–1 through Q&A–3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

Q–5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

[T.D. 8812, 64 FR 5173, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1848, Jan. 10, 2001; T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980B–1 COBRA in general.

The COBRA continuation coverage requirements are described in general in the following questions-and-answers:

Q–1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

A–1: (a) Section 4980B provides generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan. The continuation coverage requirements were added to section 162 by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99–272 (100 Stat. 222), and moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988, Public Law 100–647 (102 Stat. 3342). Continuation coverage required under section 4980B is referred to in §§ 54.4980B–1 through 54.4980B–10 as COBRA continuation coverage.

(b) COBRA also added parallel continuation coverage requirements to Part 6 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1161–1168), which is administered by the U.S. Department of Labor. If a plan does not comply with the COBRA continuation coverage requirements, the Internal Revenue Code imposes an excise tax on the employer maintaining the plan (or on the plan itself), whereas ERISA gives certain parties—including qualified beneficiaries who are participants or beneficiaries within the meaning of Title I of ERISA, as well as the Department of Labor—the right to file a lawsuit to redress the noncompliance. The rules in §§ 54.4980B–1 through 54.4980B–10 apply for purposes of section 4980B and generally also for purposes of the COBRA continuation coverage requirements in Title I of ERISA. However, certain provisions of the COBRA continuation coverage requirements (such as the definitions of group health plan, employee, and employer) are not identical in the Internal Revenue Code and Title I of ERISA. In those cases in which the statutory language is not identical, the rules in §§ 54.4980B–1 through 54.4980B–10 nonetheless apply to the COBRA continuation coverage requirements of Title I of ERISA, except to the extent those rules are inconsistent with the statutory language of Title I of ERISA.

(c) A group health plan that is subject to section 4980B (or the parallel provisions under ERISA) is referred to as being subject to COBRA. (See Q&A–4 of § 54.4980B–2). A qualified beneficiary can be required to pay for COBRA continuation coverage. The term *qualified beneficiary* is defined in Q&A–1 of § 54.4980B–3. The term *qualifying event* is defined in Q&A–1 of § 54.4980B–4. COBRA continuation coverage is described in § 54.4980B–5. The election procedures are described in § 54.4980B–6. Duration of COBRA continuation coverage is addressed in § 54.4980B–7, and payment for COBRA continuation coverage is addressed in § 54.4980B–8. Section 54.4980B–9 contains special rules for how COBRA applies in connection with business reorganizations and employer withdrawals from a multiemployer plan, and § 54.4980B–10 addresses how COBRA applies for individuals who take leave under the Family and Medical Leave Act of 1993. Unless the context indicates otherwise, any reference in §§ 54.4980B–1 through 54.4980B–10 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

Q–2: What standard applies for topics not addressed in §§ 54.4980B–1 through 54.4980B-10?

A–2: For purposes of section 4980B, for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in §§ 54.4980B–1 through 54.4980B–10 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

[T.D. 8812, 64 FR 5173, Feb 3, 1999; 64 FR 14382, Mar. 25, 1999, as amended by T.D. 8928, 66 FR 1849, Jan. 10, 2001]

§ 54.4980B–2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q–1: For purposes of section 4980B, what is a group health plan?

A–1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A–1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. (See paragraphs (b) through (e) in Q&A–8 of this section for rules regarding the application of the COBRA continuation coverage requirements to certain health flexible spending arrangements.) For purposes of this Q&A–1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A–1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A–1, and for medical savings accounts in paragraph (f) of this Q&A–1. See Q&A–6 of this section for rules to determine the number of group health plans that an employer or employee organization maintains.

(b) For purposes of §§ 54.4980B–1 through 54.4980B–10, *health care* has the same meaning as *medical care* under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program

that provides health care and thus is not a group health plan. In contrast, if an employer maintains a drug or alcohol treatment program or a health clinic, or any other facility or program that is intended to relieve or alleviate a physical condition or health problem, the facility or program is considered to be the provision of health care and so is considered a group health plan.

(c) Whether a benefit provided to employees constitutes health care is not affected by whether the benefit is excludable from income under section 132 (relating to certain fringe benefits). For example, if a department store provides its employees discounted prices on all merchandise, including health care items such as drugs or eyeglasses, the mere fact that the discounted prices also apply to health care items will not cause the program to be a plan providing health care, so long as the discount program would normally be accessible to and used by employees without regard to health needs or physical condition. If, however, the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan.

(d) The provision of health care at a facility that is located on the premises of an employer or employee organization does not constitute a group health plan if—

(1) The health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

(2) The health care is available only to current employees; and

(3) Employees are not charged for the use of the facility.

(e) A plan does not constitute a group health plan subject to COBRA if substantially all of the coverage provided under the plan is for qualified long-term care services (as defined in section 7702B(c)). For this purpose, a plan is permitted to use any reasonable method in determining whether substantially all of the coverage provided under the plan is for qualified long-term care services.

(f) Under section 106(b)(5), amounts contributed by an employer to a medical savings account (as defined in section 220(d)) are not considered part of a group health plan subject to COBRA. Thus, a plan is not required to make COBRA continuation coverage available with respect to amounts contributed by an employer to a medical savings account. A high deductible health plan does not fail to be a group health plan subject to COBRA merely because it covers a medical savings account holder.

Q–2: For purposes of section 4980B, what is the employer?

A–2: (a) For purposes of section 4980B, employer refers to—

(1) A person for whom services are performed;

(2) Any other person that is a member of a group described in section 414(b), (c), (m), or (o) that includes a person described in paragraph (a)(1) of this Q&A–2; and

(3) Any successor of a person described in paragraph (a)(1) or (2) of this Q&A–2.

(b) An employer is a successor employer if it results from a consolidation, merger, or similar restructuring of the employer or if it is a mere continuation of the employer. See paragraph (c) in Q&A–8 of § 54.4980B–9 for rules describing the circumstances in which a purchaser of substantial assets is a successor employer to the employer selling the assets.

Q–3: What is a multiemployer plan?

A–3: For purposes of §§ 54.4980B–1 through 54.4980B–10, a multiemployer plan is a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that satisfies such other requirements as the Secretary of Labor may prescribe by regulation. Whenever reference is made in §§ 54.4980B–1 through 54.4980B–10 to a plan of or maintained by an employer or employee organization, the reference includes a multiemployer plan.

Q–4: What group health plans are subject to COBRA?

A–4: (a) All group health plans are subject to COBRA except group health plans described in paragraph (b) of this Q&A–4. Group health plans described in paragraph (b) of this Q&A–4 are referred to in §§ 54.4980B–1 through 54.4980B–10 as excepted from COBRA.

(b) The following group health plans are excepted from COBRA—

(1) Small-employer plans (see Q&A–5 of this section);

(2) Church plans (within the meaning of section 414(e)); and

(3) Governmental plans (within the meaning of section 414(d)).

(c) The COBRA continuation coverage requirements generally do not apply to group health plans that are excepted from COBRA. However, a small-employer plan otherwise excepted from COBRA is nonetheless subject to COBRA with respect to qualified beneficiaries who experience a qualifying event during a period when the plan is not a small-employer plan (see paragraph (g) of Q&A–5 of this section).

(d) Although governmental plans are not subject to the COBRA continuation coverage requirements, group health plans maintained by state or local governments are generally subject to parallel continuation coverage requirements that were added by section 10003 of COBRA to the Public Health Service Act (42 U.S.C. 300bb–1 through 300bb–8), which is administered by the U.S. Department of Health and Human Services. Federal employees and their family members covered under the Federal Employees Health Benefit Program are covered by generally similar, but not parallel, temporary continuation of coverage provisions enacted by the Federal Employees Health Benefits Amendments Act of 1988. See 5 U.S.C. 8905a.

Q–5: What is a small-employer plan?

A–5: (a) Except in the case of a multiemployer plan, a *small-employer plan* is a group health plan maintained by an employer (within the meaning of Q&A–2 of this section) that normally employed fewer than 20 employees (within the meaning of paragraph (c) of this Q&A–5) during the preceding calendar year. In the case of a multiemployer plan, a *small-employer plan* is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than 20 employees during the preceding calendar year. See Q&A–6 of this section for rules to determine the number of plans that an employer or employee organization maintains. The rules of this paragraph (a) are illustrated in the following example:

Example. (i) Corporation *S* employs 12 employees, all of whom work and reside in the United States. *S* maintains a group health plan for its employees and their families. *S* is a wholly-owned subsidiary of *P*. In the previous calendar year, the controlled group of corporations including *P* and *S* employed more than 19 employees, although the only employees in the United States of the controlled group that includes *P* and *S* are the 12 employees of *S*.

(ii) Under § 1.414(b)-1 of this chapter, foreign corporations are not excluded from membership in a controlled group of corporations. Consequently, the group health plan maintained by *S* is not a small-employer plan during the current calendar year because the controlled group including *S* normally employed at least 20 employees in the preceding calendar year.

(b) An employer is considered to have normally employed fewer than 20 employees during a particular calendar year if, and only if, it had fewer than 20 employees on at least 50 percent of its typical business days during that year.

(c) All full-time and part-time common law employees of an employer are taken into account in determining whether an employer had fewer than 20 employees; however, an individual who is not a common law employee of the employer is not taken into account. Thus, the following individuals are not counted as employees for purposes of this Q&A–5 even though they are referred to as employees for all other purposes of §§ 54.4980B–1 through 54.4980B–10—

(1) Self-employed individuals (within the meaning of section 401(c)(1));

(2) Independent contractors (and their employees and independent contractors); and

(3) Directors (in the case of a corporation).

(d) In determining the number of the employees of an employer, each full-time employee is counted as one employee and each part-time employee is counted as a fraction of an employee,

determined in accordance with paragraph (e) of this Q&A–5.

(e) An employer may determine the number of its employees on a daily basis or a pay period basis. The basis used by the employer must be used with respect to all employees of the employer and must be used for the entire year for which the number of employees is being determined. If an employer determines the number of its employees on a daily basis, it must determine the actual number of full-time employees on each typical business day and the actual number of part-time employees and the hours worked by each of those part-time employees on each typical business day. Each full-time employee counts as one employee on each typical business day and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee and the denominator equal to the number of hours that must be worked on a typical business day in order to be considered a full-time employee. If an employer determines the number of its employees on a pay period basis, it must determine the actual number of full-time employees employed during that pay period and the actual number of part-time employees employed and the hours worked by each of those part-time employees during the pay period. For each day of that pay period, each full-time employee counts as one employee and each part-time employee counts as a fraction, with the numerator of the fraction equal to the number of hours worked by that employee during that pay period and the denominator equal to the number of hours that must be worked during that pay period in order to be considered a full-time employee. The determination of the number of hours required to be considered a full-time employee is based upon the employer's employment practices, except that in no event may the hours required to be considered a full-time employee exceed eight hours for any day or 40 hours for any week.

(f) In the case of a multiemployer plan, the determination of whether the plan is a small-employer plan on any particular date depends on which employers are contributing to the plan on that date and on the workforce of those employers during the preceding calendar year. If a plan that is otherwise subject to COBRA ceases to be a small-employer plan because of the addition during a calendar year of an employer that did not normally employ fewer than 20 employees on a typical business day during the preceding calendar year, the plan ceases to be excepted from COBRA immediately upon the addition of the new employer. In contrast, if the plan ceases to be a small-employer plan by reason of an increase during a calendar year in the workforce of an employer contributing to the plan, the plan ceases to be excepted from COBRA on the January 1 immediately following the calendar year in which the employer's workforce increased.

(g) A small-employer plan is generally excepted from COBRA. If, however, a plan that has been subject to COBRA (that is, was not a small-employer plan) becomes a small-employer plan, the plan remains subject to COBRA for qualifying events that occurred during the period when the plan was subject to COBRA. The rules of this paragraph (g) are illustrated by the following examples:

Example 1. An employer maintains a group health plan. The employer employed 20 employees on more than 50 percent of its working days during 2001, and consequently the plan is not excepted from COBRA during 2002. Employee *E* resigns and does not work for the employer after January 31, 2002. Under the terms of the plan, *E* is no longer eligible for coverage upon the effective date of the resignation, that is, February 1, 2002. The employer does not hire a replacement for *E*. *E* timely elects and pays for COBRA continuation coverage. The employer employs 19 employees for the remainder of 2002, and consequently the plan is not subject to COBRA in 2003. The plan must nevertheless continue to make COBRA continuation coverage available to *E* during 2003 until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until August 1, 2003, the date that is 18 months after the date of *E*'s qualifying event, or longer if *E* is eligible for a disability extension.

Example 2. The facts are the same as in *Example 1*. The employer continues to employ 19 employees throughout 2003 and 2004 and consequently the plan continues to be excepted from COBRA during 2004 and 2005.

Spouse *S* is covered under the plan because *S* is married to one of the employer's employees. On April 1, 2002, *S* is divorced from that employee and ceases to be eligible for coverage under the plan. The plan is subject to COBRA during 2002 because *X* normally employed 20 employees during 2001. *S* timely notifies the plan administrator of the divorce and timely elects and pays for COBRA continuation coverage. Even though the plan is generally excepted from COBRA during 2003, 2004, and 2005, it must nevertheless continue to make COBRA continuation coverage available to *S* during those years until the obligation to make COBRA continuation coverage available ceases under the rules of § 54.4980B–7. The obligation could continue until April 1, 2005, the date that is 36 months after the date of *S*'s qualifying event.

Example 3. The facts are the same as in *Example 2*. *C* is a dependent child of one of the employer's employees and is covered under the plan. A dependent child is no longer eligible for coverage under the plan upon the attainment of age 23. *C* attains age 23 on November 16, 2005. The plan is excepted from COBRA with respect to *C* during 2005 because the employer normally employed fewer than 20 employees during 2004. Consequently, the plan is not obligated to make COBRA continuation coverage available to *C* (and would not be obligated to make COBRA continuation coverage available to *C* even if the plan later became subject to COBRA again).

Q–6: How is the number of group health plans that an employer or employee organization maintains determined?

A–6: (a) The rules of this Q&A–6 apply in determining the number of group health plans that an employer or employee organization maintains. All references elsewhere in §§ 54.4980B–1 through 54.4980B–10 to a group health plan are references to a group health plan as determined under Q&A–1 of this section and this Q&A–6. Except as provided in paragraph (b) or (c) of this Q&A–6, all health care benefits, other than benefits for qualified long-term care services (as defined in section 7702B(c)), provided by a corporation, partnership, or other entity or trade or business, or by an employee organization, constitute one group health plan, unless—

(1) It is clear from the instruments governing an arrangement or arrangements to provide health care benefits that the benefits are being provided under separate plans; and

(2) The arrangement or arrangements are operated pursuant to such instruments as separate plans.

(b) A multiemployer plan and a nonmultiemployer plan are always separate plans.

(c) If a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion.

(d) The significance of treating an arrangement as two or more separate group health plans is illustrated by the following examples:

Example 1. (i) Employer X maintains a single group health plan, which provides major medical and prescription drug benefits. Employer Y maintains two group health plans; one provides major medical benefits and the other provides prescription drug benefits.

(ii) *X*'s plan could comply with the COBRA continuation coverage requirements by giving a qualified beneficiary experiencing a qualifying event with respect to X's plan the choice of either electing both major medical and prescription drug benefits or not receiving any COBRA continuation coverage under X's plan. By contrast, for Y's plans to comply with the COBRA continuation coverage requirements, a qualified beneficiary experiencing a qualifying event with respect to each of Y's plans must be given the choice of electing COBRA continuation coverage under either the major medical plan or the prescription drug plan or both.

Example 2. If a joint board of trustees administers one multiemployer plan, that plan will fail to qualify for the small-employer plan exception if any one of the employers whose employees are covered under the plan normally employed 20 or more employees during the preceding calendar year. However, if the joint board of trustees maintains two or more multiemployer plans, then the exception would be available with respect to each of those plans in which each of the employers whose employees are covered under the plan normally employed fewer than 20 employees during the preceding calendar year.

Q–7: What is the plan year?

A–7: (a) The *plan year* is the year that is designated as the plan year in the plan documents.

(b) If the plan documents do not designate a plan year (or if there are no plan documents), then the plan year is determined in accordance with this paragraph (b).

(1) The plan year is the deductible/limit year used under the plan.

(2) If the plan does not impose deductibles or limits on an annual basis, then the plan year is the policy year.

(3) If the plan does not impose deductibles or limits on an annual 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.

(4) In any other case, the plan year is the calendar year.

Q–8: How do the COBRA continuation coverage requirements apply to cafeteria plans and other flexible benefit arrangements?

A–8: (a)(1) The provision of health care benefits does not fail to be a group health plan merely because those benefits are offered under a cafeteria plan (as defined in section 125) or under any other arrangement under which an employee is offered a choice between health care benefits and other taxable or nontaxable benefits. However, the COBRA continuation coverage requirements apply only to the type and level of coverage under the cafeteria plan or other flexible benefit arrangement that a qualified beneficiary is actually receiving on the day before the qualifying event. See paragraphs (b) through (e) of this Q&A–8 for rules limiting the obligations of certain health flexible spending arrangements.

(2) The rules of this paragraph (a) are illustrated by the following example:

Example: (i) Under the terms of a cafeteria plan, employees can choose among life insurance coverage, membership in a health maintenance organization (HMO), coverage for medical expenses under an indemnity arrangement, and cash compensation. Of these available choices, the HMO and the indemnity arrangement are the arrangements providing health care. The instruments governing the HMO and indemnity arrangements indicate that they are separate group health plans. These group health plans are subject to COBRA. The employer does not provide any group health plan outside of the cafeteria plan. *B* and *C* are unmarried employees. *B* has chosen the life insurance coverage, and *C* has chosen the indemnity arrangement.

(ii) *B* does not have to be offered COBRA continuation coverage upon terminating employment, nor is a subsequent open enrollment period for active employees required to be made available to *B*. However, if *C* terminates employment and the termination constitutes a qualifying event, *C* must be offered an opportunity to elect COBRA continuation coverage under the indemnity arrangement. If *C* makes such an election and an open enrollment period for active employees occurs while *C* is still receiving the COBRA continuation coverage, *C* must be offered the opportunity to switch from the indemnity arrangement to the HMO (but not to the life insurance coverage because that does not constitute coverage provided under a group health plan).

(b) If a health flexible spending arrangement (health FSA), within the meaning of section 106(c)(2), satisfies the two conditions in paragraph (c) of this Q&A–8 for a plan year, the obligation of the health FSA to make COBRA continuation coverage available to a qualified beneficiary who experiences a qualifying event in that plan year is limited in accordance with paragraphs (d) and (e) of this Q&A–8, as illustrated by an example in paragraph (f) of this Q&A–8. To the extent that a health FSA is obligated to make COBRA continuation coverage available to a qualified beneficiary, the health FSA must comply with all the applicable rules of §§ 54.4980B–1 through 54.4980B–10, including the rules of Q&A–3 in § 54.4980B–5 (relating to limits).

(c) The conditions of this paragraph (c) are satisfied if—

(1) Benefits provided under the health FSA are excepted benefits within the meaning of sections 9831 and 9832; and

(2) The maximum amount that the health FSA can require to be paid for a year of COBRA continuation coverage under Q&A–1 of § 54.4980B–8 equals or exceeds the maximum benefit available under the health FSA for the year.

(d) If the conditions in paragraph (c) of this Q&A–8 are satisfied for a plan year, then the health FSA is not obligated to make COBRA continuation coverage available for any subsequent plan year to any qualified beneficiary who experiences a qualifying event during that plan year.

(e) If the conditions in paragraph (c) of this Q&A–8 are satisfied for a plan year, the health FSA is not obligated to make COBRA continuation coverage available for that plan year to any qualified beneficiary who experiences a qualifying event during that plan year

unless, as of the date of the qualifying event, the qualified beneficiary can become entitled to receive during the remainder of the plan year a benefit that exceeds the maximum amount that the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the plan year. In determining the amount of the benefit that a qualified beneficiary can become entitled to receive during the remainder of the plan year, the health FSA may deduct from the maximum benefit available to that qualified beneficiary for the year (based on the election made under the health FSA for that qualified beneficiary before the date of the qualifying event) any reimbursable claims submitted to the health FSA for that plan year before the date of the qualifying event.

(f) The rules of paragraphs (b), (c), (d), and (e) of this Q&A–8 are illustrated by the following example:

Example. (i) An employer maintains a group health plan providing major medical benefits and a group health plan that is a health FSA, and the plan year for each plan is the calendar year. Both the plan providing major medical benefits and the health FSA are subject to COBRA. Under the health FSA, during an open season before the beginning of each calendar year, employees can elect to reduce their compensation during the upcoming year by up to $1200 per year and have that same amount contributed to a health flexible spending account. The employer contributes an additional amount to the account equal to the employee's salary reduction election for the year. Thus, the maximum amount available to an employee under the health FSA for a year is two times the amount of the employee's salary reduction election for the year. This amount may be paid to the employee during the year as reimbursement for health expenses not covered by the employer's major medical plan (such as deductibles, copayments, prescription drugs, or eyeglasses). The employer determined, in accordance with section 4980B(f)(4), that a reasonable estimate of the cost of providing coverage for similarly situated nonCOBRA beneficiaries for 2002 under this health FSA is equal to two times their salary reduction election for 2002 and, thus, that two times the salary reduction election is the applicable premium for 2002.

(ii) Because the employer provides major medical benefits under another group health plan, and because the maximum benefit that any employee can receive under the health FSA is not greater than two times the employee's salary reduction election for the plan year, benefits under this health FSA are excepted benefits within the meaning of sections 9831 and 9832. Thus, the first condition of paragraph (c) of this Q&A–8 is satisfied for the year. The maximum amount that a plan can require to be paid for coverage (outside of coverage required to be made available due to a disability extension) under Q&A–1 of § 54.4980B–8 is 102 percent of the applicable premium. Thus, the maximum amount that the health FSA can require to be paid for coverage for the 2002 plan year is 2.04 times the employee's salary reduction election for the plan year. Because the maximum benefit available under the health FSA is 2.0 times the employee's salary reduction election for the year, the maximum benefit available under the health FSA for the year is less than the maximum amount that the health FSA can require to be paid for coverage for the year. Thus, the second condition in paragraph (c) of this Q&A–8 is also satisfied for the 2002 plan year. Because both conditions in paragraph (c) of this Q&A–8 are satisfied for 2002, with respect to any qualifying event occurring in 2002, the health FSA is not obligated to make COBRA continuation coverage available for any year after 2002.

(iii) Whether the health FSA is obligated to make COBRA continuation coverage available in 2002 to a qualified beneficiary with respect to a qualifying event that occurs in 2002 depends upon the maximum benefit that would be available to the qualified beneficiary under COBRA continuation coverage for that plan year. *Case 1:* Employee *B* has elected to reduce *B*'s salary by $1200 for 2002. Thus, the maximum benefit that *B* can become entitled to receive under the health FSA during the entire year is $2400. *B* experiences a qualifying event that is the termination of *B*'s employment on May 31, 2002. As of that date, *B* had submitted $300 of reimbursable expenses under the health FSA. Thus, the maximum benefit that *B* could become entitled to receive for the remainder of 2002 is $2100. The maximum amount that the health FSA can require to be paid for COBRA continuation coverage for the remainder of 2002 is 102 percent times 1/12 of the applicable premium for 2002 times the number of months remaining in 2002 after the date of the qualifying event. In *B*'s case, the maximum amount that the health FSA can require to be paid for COBRA continuation coverage for 2002 is 2.04 times $1200, or $2448. One-twelfth of $2448 is $204. Because seven months remain in the plan year, the maximum amount that the health FSA can require to be paid for *B*'s coverage for the remainder of the year is seven times $204, or $1428. Because $1428 is less than the maximum benefit that *B* could become entitled to receive for the remainder of the year ($2100), the health FSA is required to make COBRA continuation coverage available to *B*

for the remainder of 2002 (but not for any subsequent year).

(iv) *Case 2:* The facts are the same as in *Case 1* except that *B* had submitted $1000 of reimbursable expenses as of the date of the qualifying event. In that case, the maximum benefit available to *B* for the remainder of the year would be $1400 instead of $2100. Because the maximum amount that the health FSA can require to be paid for *B*'s coverage is $1428, and because the $1400 maximum benefit for the remainder of the year does not exceed $1428, the health FSA is not obligated to make COBRA continuation coverage available to *B* in 2002 (or any later year). (Of course, the administrator of the health FSA is permitted to make COBRA continuation coverage available to every qualified beneficiary in the year that the qualified beneficiary's qualifying event occurs in order to avoid having to determine the maximum benefit available for each qualified beneficiary for the remainder of the plan year.)

Q–9: What is the effect of a group health plan's failure to comply with the requirements of section 4980B(f)?

A–9: Under section 4980B(a), if a group health plan subject to COBRA fails to comply with section 4980B(f), an excise tax is imposed. Moreover, non-tax remedies may be available if the plan fails to comply with the parallel requirements in ERISA, which are administered by the Department of Labor.

Q–10: Who is liable for the excise tax if a group health plan fails to comply with the requirements of section 4980B(f)?

A–10: (a) In general, the excise tax is imposed on the employer maintaining the plan, except that in the case of a multiemployer plan (see Q&A–3 of this section for a definition of multiemployer plan) the excise tax is imposed on the plan.

(b) In certain circumstances, the excise tax is also imposed on a person involved with the provision of benefits under the plan (other than in the capacity of an employee), such as an insurer providing benefits under the plan or a third party administrator administering claims under the plan. In general, such a person will be liable for the excise tax if the person assumes, under a legally enforceable written agreement, the responsibility for performing the act to which the failure to comply with the COBRA continuation coverage requirements relates. Such a person will be liable for the excise tax notwithstanding the absence of a written agreement assuming responsibility for complying with COBRA if the person provides coverage under the plan to a similarly situated nonCOBRA beneficiary (see Q&A–3 of § 54.4980B–3 for a definition of similarly situated nonCOBRA beneficiaries) and the employer or plan administrator submits a written request to the person to provide to a qualified beneficiary the same coverage that the person provides to the similarly situated nonCOBRA beneficiary. If the person providing coverage under the plan to a similarly situated nonCOBRA beneficiary is the plan administrator and the qualifying event is a divorce or legal separation or a dependent child's ceasing to be covered under the generally applicable requirements of the plan, the plan administrator will also be liable for the excise tax if the qualified beneficiary submits a written request for coverage.

Q–11: If a person is liable for the excise tax under section 4980B, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–11: (a) *In general. See* §§ 54.6011–2 and 54.6151–1.

(b) *Due date for filing of return by employers or other persons responsible for benefits under a group health plan. See* § 54.6071–1(a)(1).

(c) *Due date for filing of return by multiemployer plans. See* § 54.6071–1(a)(2).

(d) *Effective/applicability date.* In the case of an employer or other person mentioned in paragraph (b) of this Q & A–11, the rules in this Q & A–11 are effective for taxable years beginning on or after January 1, 2010. In the case of a plan mentioned in paragraph (c) of this Q & A–11, the rules in this Q & A–11 are effective for plan years beginning on or after January 1, 2010.

[T.D. 8812, 64 FR 5174, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1849, Jan. 10, 2001; T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980B–3 Qualified beneficiaries.

The determination of who is a qualified beneficiary, an employee, or a covered employee, and of who are the similarly situated nonCOBRA beneficiaries is addressed in the following questions-and-answers:

Q–1: Who is a qualified beneficiary?

A–1: (a)(1) Except as set forth in paragraphs (c) through (f) of this Q&A–1, a qualified beneficiary is—

(i) Any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee; or

(ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.

(2) In the case of a qualifying event that is the bankruptcy of the employer, a covered employee who had retired on or before the date of substantial elimination of group health plan coverage is also a qualified beneficiary, as is any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan.

(3) In general, an individual (other than a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) who is not covered under a plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event, and the reason for the individual's lack of actual coverage (such as the individual's having declined participation in the plan or failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the individual is denied or not offered coverage under a plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101–12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§ 54.4980B–1 through 54.4980B–10, the individual will be considered to have had the coverage that was wrongfully denied or not offered.

(4) Paragraph (b) of this Q&A–1 describes how certain family members are not qualified beneficiaries even if they become covered under the plan; paragraphs (c), (d), and (e) of this Q&A–1 place limits on the general rules of this paragraph (a) concerning who is a qualified beneficiary; paragraph (f) of this Q&A–1 provides when an individual who has been a qualified beneficiary ceases to be a qualified beneficiary; paragraph (g) of this Q&A–1 defines *placed for adoption*; and paragraph (h) of this Q&A–1 contains examples.

(b) In contrast to a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, an individual who marries any qualified beneficiary on or after the date of the qualifying event and a newborn or adopted child (other than one born to or placed for adoption with a covered employee) are not qualified beneficiaries by virtue of the marriage, birth, or placement for adoption or by virtue of the individual's status as the spouse or the child's status as a dependent of the qualified beneficiary. These new family members do not themselves become qualified beneficiaries even if they become covered under the plan. (For situations in which a plan is required to make coverage available to new family members of a qualified beneficiary who is receiving COBRA continuation coverage, see Q&A–5 of § 54.4980B–5, paragraph (c) in Q&A–4 of § 54.4980B–5, and section 9801(f)(2).)

(c) An individual is not a qualified beneficiary if, on the day before the qualifying event referred to in paragraph (a) of this Q&A–1, the individual is covered under the group health plan by reason of another individual's election of COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event.

(d) A covered employee can be a qualified beneficiary only in connection with a qualifying event that is the termination, or reduction of hours, of the covered employee's employment, or that is the bankruptcy of the employer.

(e) An individual is not a qualified beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from

the individual's employer no earned income (within the meaning of section 911(d)(2)) that constituted income from sources within the United States (within the meaning of section 861(a)(3)). If, pursuant to the preceding sentence, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual is not considered a qualified beneficiary by virtue of the relationship to the individual.

(f) A qualified beneficiary who does not elect COBRA continuation coverage in connection with a qualifying event ceases to be a qualified beneficiary at the end of the election period (see Q&A–1 of § 54.4980B–6). Thus, for example, if such a former qualified beneficiary is later added to a covered employee's coverage (e.g., during an open enrollment period) and then another qualifying event occurs with respect to the covered employee, the former qualified beneficiary does not become a qualified beneficiary by reason of the second qualifying event. If a covered employee who is a qualified beneficiary does not elect COBRA continuation coverage during the election period, then any child born to or placed for adoption with the covered employee on or after the date of the qualifying event is not a qualified beneficiary. Once a plan's obligation to make COBRA continuation coverage available to an individual who has been a qualified beneficiary ceases under the rules of § 54.4980B–7, the individual ceases to be a qualified beneficiary.

(g) For purposes of §§ 54.4980B–1 through 54.4980B–10, *placement for adoption* or *being placed for adoption* means the assumption and retention by the covered employee of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement for adoption with the covered employee terminates upon the termination of the legal obligation for total or partial support. A child who is immediately adopted by the covered employee without a preceding placement for adoption is considered to be placed for adoption on the date of the adoption.

(h) The rules of this Q&A–1 are illustrated by the following examples:

Example 1. (i) *B* is a single employee who voluntarily terminates employment and elects COBRA continuation coverage under a group health plan. To comply with the requirements of section 9801(f), the plan permits a covered employee who marries to have her or his spouse covered under the plan. One month after electing COBRA continuation coverage, *B* marries and chooses to have *B*'s spouse covered under the plan.

(ii) *B*'s spouse is not a qualified beneficiary. Thus, if *B* dies during the period of COBRA continuation coverage, the plan does not have to offer *B*'s surviving spouse an opportunity to elect COBRA continuation coverage.

Example 2. (i) *C* is a married employee who terminates employment. *C* elects COBRA continuation coverage for *C* but not *C*'s spouse, and *C*'s spouse declines to elect such coverage. *C*'s spouse thus ceases to be a qualified beneficiary. At the next open enrollment period, *C* adds the spouse as a beneficiary under the plan.

(ii) The addition of the spouse during the open enrollment period does not make the spouse a qualified beneficiary. The plan thus will not have to offer the spouse an opportunity to elect COBRA continuation coverage upon a later divorce from or death of *C*.

Example 3. (i) Under the terms of a group health plan, a covered employee's child, upon attaining age 19, ceases to be a dependent eligible for coverage.

(ii) At that time, the child must be offered an opportunity to elect COBRA continuation coverage. If the child elects COBRA continuation coverage, the child marries during the period of the COBRA continuation coverage, and the child's spouse becomes covered under the group health plan, the child's spouse is not a qualified beneficiary.

Example 4. (i) *D* is a single employee who, upon retirement, is given the opportunity to elect COBRA continuation coverage but declines it in favor of an alternative offer of 12 months of employer-paid retiree health benefits. At the end of the election period, *D* ceases to be a qualified beneficiary and will not have to be given another opportunity to elect COBRA continuation coverage (at the end of those 12 months or at any other time). *D* marries *E* during the period of retiree health coverage and, under the terms of that coverage, *E* becomes covered under the plan.

(ii) If a divorce from or death of *D* will result in *E*'s losing coverage, *E* will be a qualified beneficiary because *E*'s coverage under the plan on the day before the qualifying event (that is, the divorce or death) will have been by reason of *D*'s acceptance of 12 months of employer-paid coverage after the prior qualifying event (*D*'s retirement) rather than by reason of an election of COBRA continuation coverage.

Example 5. (i) The facts are the same as in *Example 4*, except that, under the terms of the plan, the divorce or death does not cause

E to lose coverage so that *E* continues to be covered for the balance of the original 12-month period.

(ii) *E* does not have to be allowed to elect COBRA continuation coverage because the loss of coverage at the end of the 12-month period is not caused by the divorce or death, and thus the divorce or death does not constitute a qualifying event. See Q&A–1 of § 54.4980B–4.

Q–2: Who is an employee and who is a covered employee?

A–2: (a)(1) For purposes of §§ 54.4980B–1 through 54.4980B–10 (except for purposes of Q&A–5 in § 54.4980B–2, relating to the exception from COBRA for plans maintained by an employer with fewer than 20 employees), an *employee* is any individual who is eligible to be covered under a group health plan by virtue of the performance of services for the employer maintaining the plan or by virtue of membership in the employee organization maintaining the plan. Thus, for purposes of §§ 54.4980B–1 through 54.4980B–10 (except for purposes of Q&A–5 in § 54.4980B–2), the following individuals are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan—

(i) Self-employed individuals (within the meaning of section 401(c)(1));

(ii) Independent contractors (and their employees and independent contractors); and

(iii) Directors (in the case of a corporation).

(2) Similarly, whenever reference is made in §§ 54.4980B–1 through 54.4980B–10 (except in Q&A–5 of § 54.4980B–2) to an employment relationship (such as by referring to the termination of employment of an employee or to an employee's being employed by an employer), the reference includes the relationship of those individuals who are employees within the meaning of this paragraph (a). See paragraph (c) in Q&A–5 of § 54.4980B–2 for a narrower meaning of employee solely for purposes of Q&A–5 of § 54.4980B–2.

(b) For purposes of §§ 54.4980B–1 through 54.4980B–10, a *covered employee* is any individual who is (or was) provided coverage under a group health plan (other than a plan that is excepted from COBRA on the date of the qualifying event; see Q&A–4 of § 54.4980B–2) by virtue of being or having been an employee. For example, a retiree or former employee who is covered by a group health plan is a covered employee if the coverage results in whole or in part from her or his previous employment. An employee (or former employee) who is merely eligible for coverage under a group health plan is generally not a covered employee if the employee (or former employee) is not actually covered under the plan. In general, the reason for the employee's (or former employee's) lack of actual coverage (such as having declined participation in the plan or having failed to satisfy the plan's conditions for participation) is not relevant for this purpose. However, if the employee (or former employee) is denied or not offered coverage under circumstances in which the denial or failure to offer constitutes a violation of applicable law (such as the Americans with Disabilities Act, 42 U.S.C. 12101 through 12213, the special enrollment rules of section 9801, or the requirements of section 9802 prohibiting discrimination in eligibility to enroll in a group health plan based on health status), then, for purposes of §§ 54.4980B–1 through 54.4980B–10, the employee (or former employee) will be considered to have had the coverage that was wrongfully denied or not offered.

Q–3: Who are the similarly situated nonCOBRA beneficiaries?

A–3: For purposes of §§ 54.4980B–1 through 54.4980B–10, *similarly situated nonCOBRA beneficiaries* means the group of covered employees, spouses of covered employees, or dependent children of covered employees receiving coverage under a group health plan maintained by the employer or employee organization who are receiving that coverage for a reason other than the rights provided under the COBRA continuation coverage requirements and who, based on all of the facts and circumstances, are most similarly situated to the situation of the qualified beneficiary immediately before the qualifying event.

[T.D. 8812, 64 FR 5176, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1852, Jan. 10, 2001]

§ 54.4980B–4 Qualifying events.

The determination of what constitutes a qualifying event is addressed in the following questions and answers:

Q–1: What is a qualifying event?

A–1: (a) A *qualifying event* is an event that satisfies paragraphs (b), (c), and (d) of this Q&A–1. Paragraph (e) of this Q&A–1 further explains a reduction of hours of employment, paragraph (f) of this Q&A–1 describes the treatment of children born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and paragraph (g) of this Q&A–1 contains examples. See Q&A–1 through Q&A–3 of § 54.4980B–10 for special rules in the case of leave taken under the Family and Medical Leave Act of 1993 (29 U.S.C. 2601–2619).

(b) An event satisfies this paragraph (b) if the event is any of the following—

(1) The death of a covered employee;

(2) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment;

(3) The divorce or legal separation of a covered employee from the employee's spouse;

(4) A covered employee's becoming entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg);

(5) A dependent child's ceasing to be a dependent child of a covered employee under the generally applicable requirements of the plan; or

(6) A proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

(c) An event satisfies this paragraph (c) if, under the terms of the group health plan, the event causes the covered employee, or the spouse or a dependent child of the covered employee, to lose coverage under the plan. For this purpose, to lose coverage means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. Any increase in the premium or contribution that must be paid by a covered employee (or the spouse or dependent child of a covered employee) for coverage under a group health plan that results from the occurrence of one of the events listed in paragraph (b) of this Q&A–1 is a loss of coverage. In the case of an event that is the bankruptcy of the employer, lose coverage also means any substantial elimination of coverage under the plan, occurring within 12 months before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage or for any spouse, surviving spouse, or dependent child of such a covered employee if, on the day before the bankruptcy qualifying event, the spouse, surviving spouse, or dependent child is a beneficiary under the plan. For purposes of this paragraph (c), a loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum coverage period (see Q&A–4 and Q&A–6 of § 54.4980B–7). However, if neither the covered employee nor the spouse or a dependent child of the covered employee loses coverage before the end of what would be the maximum coverage period, the event does not satisfy this paragraph (c). If coverage is reduced or eliminated in anticipation of an event (for example, an employer's eliminating an employee's coverage in anticipation of the termination of the employee's employment, or an employee's eliminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(d) An event satisfies this paragraph (d) if it occurs while the plan is subject to COBRA. Thus, an event will not satisfy this paragraph (d) if it occurs while the plan is excepted from COBRA (see Q&A–4 of § 54.4980B–2). Even if the plan later becomes subject to COBRA, it is not required to make COBRA continuation coverage available to anyone whose coverage ends as a result of an event during a year in which the plan is excepted from COBRA. For example, if a group health plan is excepted from COBRA as a small-employer plan during the year 2001 (see Q&A–5 of § 54.4980B–2) and an employee terminates employment on December 31,

2001, the termination is not a qualifying event and the plan is not required to permit the employee to elect COBRA continuation coverage. This is the case even if the plan ceases to be a small-employer plan as of January 1, 2002. Also, the same result will follow even if the employee is given three months of coverage beyond December 31 (that is, through March of 2002), because there will be no qualifying event as of the termination of coverage in March. However, if the employee's spouse is initially provided with the three-month coverage through March 2002, but the spouse divorces the employee before the end of the three months and loses coverage as a result of the divorce, the divorce will constitute a qualifying event during 2002 and so entitle the spouse to elect COBRA continuation coverage. See Q&A–7 of § 54.4980B–7 regarding the maximum coverage period in such a case.

(e) A reduction of hours of a covered employee's employment occurs whenever there is a decrease in the hours that a covered employee is required to work or actually works, but only if the decrease is not accompanied by an immediate termination of employment. This is true regardless of whether the covered employee continues to perform services following the reduction of hours of employment. For example, an absence from work due to disability, a temporary layoff, or any other reason (other than due to leave that is FMLA leave; see § 54.4980B–10) is a reduction of hours of a covered employee's employment if there is not an immediate termination of employment. If a group health plan measures eligibility for the coverage of employees by the number of hours worked in a given time period, such as the preceding month or quarter, and an employee covered under the plan fails to work the minimum number of hours during that time period, the failure to work the minimum number of required hours is a reduction of hours of that covered employee's employment.

(f) The qualifying event of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the qualifying event giving rise to the period of COBRA continuation coverage during which the child is born or placed for adoption. If a second qualifying event has occurred before the child is born or placed for adoption (such as the death of the covered employee), then the second qualifying event also applies to the newborn or adopted child. See Q&A–6 of § 54.4980B–7.

(g) The rules of this Q&A–1 are illustrated by the following examples, in each of which the group health plan is subject to COBRA:

Example 1. (i) An employee who is covered by a group health plan terminates employment (other than by reason of the employee's gross misconduct) and, beginning with the day after the last day of employment, is given 3 months of employer-paid coverage under the same terms and conditions as before that date. At the end of the three months, the coverage terminates.

(ii) The loss of coverage at the end of the three months results from the termination of employment and, thus, the termination of employment is a qualifying event.

Example 2. (i) An employee who is covered by a group health plan retires (which is a termination of employment other than by reason of the employee's gross misconduct) and, upon retirement, is required to pay an increased amount for the same group health coverage that the employee had before retirement.

(ii) The increase in the premium or contribution required for coverage is a loss of coverage under paragraph (c) of this Q&A–1 and, thus, the retirement is a qualifying event.

Example 3. (i) An employee and the employee's spouse are covered under an employer's group health plan. The employee retires and is given identical coverage for life. However, the plan provides that the spousal coverage will not be continued beyond six months unless a higher premium for the spouse is paid to the plan.

(ii) The requirement for the spouse to pay a higher premium at the end of the six months is a loss of coverage under paragraph (c) of this Q&A–1. Thus, the retirement is a qualifying event and the spouse must be given an opportunity to elect COBRA continuation coverage.

Example 4. (i) *F* is a covered employee who is married to *G*, and both are covered under a group health plan maintained by *F*'s employer. *F* and *G* are divorced. Under the terms of the plan, the divorce causes *G* to lose coverage. The divorce is a qualifying event, and *G* elects COBRA continuation coverage, remarries during the period of COBRA continuation coverage, and *G*'s new spouse

becomes covered under the plan. (See Q&A–5 in § 54.4980B–5, paragraph (c) in Q&A–4 of § 54.4980B–5, and section 9801(f)(2).) *G* dies. Under the terms of the plan, the death causes *G*'s new spouse to lose coverage under the plan.

(ii) *G*'s death is not a qualifying event because *G* is not a covered employee.

Example 5. (i) An employer maintains a group health plan for both active employees and retired employees (and their families). The coverage for active employees and retired employees is identical, and the employer does not require retirees to pay more for coverage than active employees. The plan does not make COBRA continuation coverage available when an employee retires (and is not required to because the retired employee has not lost coverage under the plan). The employer amends the plan to eliminate coverage for retired employees effective January 1, 2002. On that date, several retired employees (and their spouses and dependent children) have been covered under the plan since their retirement for less than the maximum coverage period that would apply to them in connection with their retirement.

(ii) The elimination of retiree coverage under these circumstances is a deferred loss of coverage for those retirees (and their spouses and dependent children) under paragraph (c) of this Q&A–1 and, thus, the retirement is a qualifying event. The plan must make COBRA continuation coverage available to them for the balance of the maximum coverage period that applies to them in connection with the retirement.

Q–2: Are the facts surrounding a termination of employment (such as whether it was voluntary or involuntary) relevant in determining whether the termination of employment is a qualifying event?

A–2: Apart from facts constituting gross misconduct, the facts surrounding the termination or reduction of hours are irrelevant in determining whether a qualifying event has occurred. Thus, it does not matter whether the employee voluntarily terminated or was discharged. For example, a strike or a lockout is a termination or reduction of hours that constitutes a qualifying event if the strike or lockout results in a loss of coverage as described in paragraph (c) of Q&A–1 of this section. Similarly, a layoff that results in such a loss of coverage is a qualifying event.

[T.D. 8812, 64 FR 5178, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1852, Jan. 10, 2001]

§ 54.4980B–5 COBRA continuation coverage.

The following questions-and-answers address the requirements for coverage to constitute COBRA continuation coverage:

Q–1: What is COBRA continuation coverage?

A–1: (a) If a qualifying event occurs, each qualified beneficiary (other than a qualified beneficiary for whom the qualifying event will not result in any immediate or deferred loss of coverage) must be offered an opportunity to elect to receive the group health plan coverage that is provided to similarly situated nonCOBRA beneficiaries (ordinarily, the same coverage that the qualified beneficiary had on the day before the qualifying event). See Q&A–3 of § 54.4980B–3 for the definition of similarly situated nonCOBRA beneficiaries. This coverage is COBRA continuation coverage. If coverage is modified for similarly situated nonCOBRA beneficiaries, then the coverage made available to qualified beneficiaries is modified in the same way. If the continuation coverage offered differs in any way from the coverage made available to similarly situated nonCOBRA beneficiaries, the coverage offered does not constitute COBRA continuation coverage and the group health plan is not in compliance with COBRA unless other coverage that does constitute COBRA continuation coverage is also offered. Any elimination or reduction of coverage in anticipation of an event described in paragraph (b) of Q&A–1 of § 54.4980B–4 is disregarded for purposes of this Q&A–1 and for purposes of any other reference in §§ 54.4980B–1 through 54.4980B–10 to coverage in effect immediately before (or on the day before) a qualifying event. COBRA continuation coverage must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(b) In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the child is generally entitled to elect immediately to have the same coverage that dependent children of active employees receive under the benefit packages under which the covered employee has coverage at the time

of the birth or placement for adoption. Such a child would be entitled to elect coverage different from that elected by the covered employee during the next available open enrollment period under the plan. See Q&A–4 of this section.

Q–2: What deductibles apply if COBRA continuation coverage is elected?

A–2: (a) Qualified beneficiaries electing COBRA continuation coverage generally are subject to the same deductibles as similarly situated nonCOBRA beneficiaries. If a qualified beneficiary's COBRA continuation coverage begins before the end of a period prescribed for accumulating amounts toward deductibles, the qualified beneficiary must retain credit for expenses incurred toward those deductibles before the beginning of COBRA continuation coverage as though the qualifying event had not occurred. The specific application of this rule depends on the type of deductible, as set forth in paragraphs (b) through (d) of this Q&A–2. Special rules are set forth in paragraph (e) of this Q&A–2, and examples appear in paragraph (f) of this Q&A–2.

(b) If a deductible is computed separately for each individual receiving coverage under the plan, each individual's remaining deductible amount (if any) on the date COBRA continuation coverage begins is equal to that individual's remaining deductible amount immediately before that date.

(c) If a deductible is computed on a family basis, the remaining deductible for the family on the date that COBRA continuation coverage begins depends on the members of the family electing COBRA continuation coverage. In computing the family deductible that remains on the date COBRA continuation coverage begins, only the expenses of those family members receiving COBRA continuation coverage need be taken into account. If the qualifying event results in there being more than one family unit (for example, because of a divorce), the family deductible may be computed separately for each resulting family unit based on the members in each unit. These rules apply regardless of whether the plan provides that the family deductible is an alternative to individual deductibles or an additional requirement.

(d) Deductibles that are not described in paragraph (b) or (c) of this Q&A–2 must be treated in a manner consistent with the principles set forth in those paragraphs.

(e) If a deductible is computed on the basis of a covered employee's compensation instead of being a fixed dollar amount and the employee remains employed during the period of COBRA continuation coverage, the plan is permitted to choose whether to apply the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began, or to apply the deductible by taking the employee's actual compensation into account. In applying a deductible that is computed on the basis of the covered employee's compensation instead of being a fixed dollar amount, for periods of COBRA continuation coverage in which the employee is not employed by the employer, the plan is required to compute the deductible by treating the employee's compensation as continuing without change for the duration of the COBRA continuation coverage either at the level that was used to compute the deductible in effect immediately before the COBRA continuation coverage began or at the level that was used to compute the deductible in effect immediately before the employee's employment was terminated.

(f) The rules of this Q&A–2 are illustrated by the following examples; in each example, deductibles under the plan are determined on a calendar year basis:

Example 1. (i) A group health plan applies a separate $100 annual deductible to each individual it covers. The plan provides that the spouse and dependent children of a covered employee will lose coverage on the last day of the month after the month of the covered employee's death. A covered employee dies on June 11, 2001. The spouse and the two dependent children elect COBRA continuation coverage, which will begin on August 1, 2001. As of July 31, 2001, the spouse has incurred $80 of covered expenses, the older child has

incurred no covered expenses, and the younger one has incurred $120 of covered expenses (and therefore has already satisfied the deductible).

(ii) At the beginning of COBRA continuation coverage on August 1, the spouse has a remaining deductible of $20, the older child still has the full $100 deductible, and the younger one has no further deductible.

Example 2. (i) A group health plan applies a separate $200 annual deductible to each individual it covers, except that each family member is treated as having satisfied the individual deductible once the family has incurred $500 of covered expenses during the year. The plan provides that upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. A covered employee with four dependent children is divorced, the spouse obtains custody of the two oldest children, and the spouse and those children all elect COBRA continuation coverage to begin immediately. The family had accumulated $420 of covered expenses before the divorce, as follows: $70 by each parent, $200 by the oldest child, $80 by the youngest child, and none by the other two children.

(ii) The resulting family consisting of the spouse and the two oldest children accumulated a total of $270 of covered expenses, and thus the remaining deductible for that family could be as high as $230 (because the plan would not have to count the incurred expenses of the covered employee and the youngest child). The remaining deductible for the resulting family consisting of the covered employee and the two youngest children is not subject to the rules of this Q&A–2 because their coverage is not COBRA continuation coverage.

Example 3. Each year a group health plan pays 70 percent of the cost of an individual's psychotherapy after that individual's first three visits during the year. A qualified beneficiary whose election of COBRA continuation coverage takes effect beginning August 1, 2001 and who has already made two visits as of that date need only pay for one more visit before the plan must begin to pay 70 percent of the cost of the remaining visits during 2001.

Example 4. (i) A group health plan has a $250 annual deductible per covered individual. The plan provides that if the deductible is not satisfied in a particular year, expenses incurred during October through December of that year are credited toward satisfaction of the deductible in the next year. A qualified beneficiary who has incurred covered expenses of $150 from January through September of 2001 and $40 during October elects COBRA continuation coverage beginning November 1, 2001.

(ii) The remaining deductible amount for this qualified beneficiary is $60 at the beginning of the COBRA continuation coverage. If this individual incurs covered expenses of $50 in November and December of 2001 combined (so that the $250 deductible for 2001 is not satisfied), the $90 incurred from October through December of 2001 are credited toward satisfaction of the deductible amount for 2002.

Q–3: How do a plan's limits apply to COBRA continuation coverage?

A–3: (a) Limits are treated in the same way as deductibles (see Q&A–2 of this section). This rule applies both to limits on plan benefits (such as a maximum number of hospital days or dollar amount of reimbursable expenses) and limits on out-of-pocket expenses (such as a limit on copayments, a limit on deductibles plus copayments, or a catastrophic limit). This rule applies equally to annual and lifetime limits and applies equally to limits on specific benefits and limits on benefits in the aggregate under the plan.

(b) The rule of this Q&A–3 is illustrated by the following examples; in each example limits are determined on a calendar year basis:

Example 1. (i) A group health plan pays for a maximum of 150 days of hospital confinement per individual per year. A covered employee who has had 20 days of hospital confinement as of May 1, 2001 terminates employment and elects COBRA continuation coverage as of that date.

(ii) During the remainder of the year 2001 the plan need only pay for a maximum of 130 days of hospital confinement for this individual.

Example 2. (i) A group health plan reimburses a maximum of $20,000 of covered expenses per family per year, and the same $20,000 limit applies to unmarried covered employees. A covered employee and spouse who have no children divorce on May 1, 2001, and the spouse elects COBRA continuation coverage as of that date. In 2001, the employee had incurred $5,000 of expenses and the spouse had incurred $8,000 before May 1.

(ii) The plan can limit its reimbursement of the amount of expenses incurred by the spouse on and after May 1 for the remainder of the year to $12,000 ($20,000 − $8,000 = $12,000). The remaining limit for the employee is not subject to the rules of this Q&A–3 because the employee's coverage is not COBRA continuation coverage.

Example 3. (i) A group health plan pays for 80 percent of covered expenses after satisfaction of a $100-per-individual deductible, and the plan pays for 100 percent of covered expenses after a family has incurred out-of-pocket costs of $2,000. The plan provides that

upon the divorce of a covered employee, coverage will end immediately for the employee's spouse and any children who do not remain in the employee's custody. An employee and spouse with three dependent children divorce on June 1, 2001, and one of the children remains with the employee. The spouse elects COBRA continuation coverage as of that date for the spouse and the other two children. During January through May of 2001, the spouse incurred $600 of covered expenses and each of the two children in the spouse's custody after the divorce incurred covered expenses of $1,100. This resulted in total out-of-pocket costs for these three individuals of $800 ($300 total for the three deductibles, plus $500 for 20 percent of the other $2,500 in incurred expenses [$600 + $1,100 + $1,100 = $2,800; $2,800 − $300 = $2,500]).

(ii) For the remainder of 2001, the resulting family consisting of the spouse and two children has an out-of-pocket limit of $1,200 ($2,000 − $800 = $1,200) . The remaining out-of-pocket limit for the resulting family consisting of the employee and one child is not subject to the rules of this Q&A–3 because their coverage is not COBRA continuation coverage.

Q–4: Can a qualified beneficiary who elects COBRA continuation coverage ever change from the coverage received by that individual immediately before the qualifying event?

A–4: (a) In general, a qualified beneficiary need only be given an opportunity to continue the coverage that she or he was receiving immediately before the qualifying event. This is true regardless of whether the coverage received by the qualified beneficiary before the qualifying event ceases to be of value to the qualified beneficiary, such as in the case of a qualified beneficiary covered under a region-specific health maintenance organization (HMO) who leaves the HMO's service region. The only situations in which a qualified beneficiary must be allowed to change from the coverage received immediately before the qualifying event are as set forth in paragraphs (b) and (c) of this Q&A–4 and in Q&A–1 of this section (regarding changes to or elimination of the coverage provided to similarly situated nonCOBRA beneficiaries).

(b) If a qualified beneficiary participates in a region-specific benefit package (such as an HMO or an on-site clinic) that will not service her or his health needs in the area to which she or he is relocating (regardless of the reason for the relocation), the qualified beneficiary must be given, within a reasonable period after requesting other coverage, an opportunity to elect alternative coverage that the employer or employee organization makes available to active employees. If the employer or employee organization makes group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating, then that coverage is the alternative coverage that must be made available to the relocating qualified beneficiary. If the employer or employee organization does not make group health plan coverage available to similarly situated nonCOBRA beneficiaries that can be extended in the area to which the qualified beneficiary is relocating but makes coverage available to other employees that can be extended in that area, then the coverage made available to those other employees must be made available to the relocating qualified beneficiary. The effective date of the alternative coverage must be not later than the date of the qualified beneficiary's relocation, or, if later, the first day of the month following the month in which the qualified beneficiary requests the alternative coverage. However, the employer or employee organization is not required to make any other coverage available to the relocating qualified beneficiary if the only coverage the employer or employee organization makes available to active employees is not available in the area to which the qualified beneficiary relocates (because all such coverage is region-specific and does not service individuals in that area).

(c) If an employer or employee organization makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. An open enrollment period means a period during which an employee covered under a plan can choose to be covered under another group health plan or under another benefit package within the same

plan, or to add or eliminate coverage of family members.

(d) The rules of this Q&A–4 are illustrated by the following examples:

Example 1. (i) *E* is an employee who works for an employer that maintains several group health plans. Under the terms of the plans, if an employee chooses to cover any family members under a plan, all family members must be covered by the same plan and that plan must be the same as the plan covering the employee. Immediately before *E*'s termination of employment (for reasons other than gross misconduct), *E* is covered along with *E*'s spouse and children by a plan. The coverage under that plan will end as a result of the termination of employment.

(ii) Upon *E*'s termination of employment, each of the four family members is a qualified beneficiary. Even though the employer maintains various other plans and options, it is not necessary for the qualified beneficiaries to be allowed to switch to a new plan when *E* terminates employment.

(iii) COBRA continuation coverage is elected for each of the four family members. Three months after *E*'s termination of employment there is an open enrollment period during which similarly situated active employees are offered an opportunity to choose to be covered under a new plan or to add or eliminate family coverage.

(iv) During the open enrollment period, each of the four qualified beneficiaries must be offered the opportunity to switch to another plan (as though each qualified beneficiary were an individual employee). For example, each member of *E*'s family could choose coverage under a separate plan, even though the family members of employed individuals could not choose coverage under separate plans. Of course, if each family member chooses COBRA continuation coverage under a separate plan, the plan can require payment for each family member that is based on the applicable premium for individual coverage under that separate plan. See Q&A–1 of § 54.4980B–8.

Example 2. (i) The facts are the same as in *Example 1*, except that *E*'s family members are not covered under *E*'s group health plan when *E* terminates employment.

(ii) Although the family members do not have to be given an opportunity to elect COBRA continuation coverage, *E* must be allowed to add them to *E*'s COBRA continuation coverage during the open enrollment period. This is true even though the family members are not, and cannot become, qualified beneficiaries (see Q&A–1 of § 54.4980B–3).

Q–5: Aside from open enrollment periods, can a qualified beneficiary who has elected COBRA continuation coverage choose to cover individuals (such as newborn children, adopted children, or new spouses) who join the qualified beneficiary's family on or after the date of the qualifying event?

A–5: (a) Yes. Under section 9801, employees eligible to participate in a group health plan (whether or not participating), as well as former employees participating in a plan (referred to in those rules as participants), are entitled to special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption, if certain requirements are satisfied. Employees not participating in the plan also can obtain rights for self-enrollment under those rules. Once a qualified beneficiary is receiving COBRA continuation coverage (that is, has timely elected and made timely payment for COBRA continuation coverage), the qualified beneficiary has the same right to enroll family members under those special enrollment rules as if the qualified beneficiary were an employee or participant within the meaning of those rules. However, neither a qualified beneficiary who is not receiving COBRA continuation coverage nor a former qualified beneficiary has any special enrollment rights under those rules.

(b) In addition to the special enrollment rights described in paragraph (a) of this Q&A–5, if the plan covering the qualified beneficiary provides that new family members of active employees can become covered (either automatically or upon an appropriate election) before the next open enrollment period, then the same right must be extended to the new family members of a qualified beneficiary.

(c) If the addition of a new family member will result in a higher applicable premium (for example, if the qualified beneficiary was previously receiving COBRA continuation coverage as an individual, or if the applicable premium for family coverage depends on family size), the plan can require the payment of a correspondingly higher amount for the COBRA continuation coverage. See Q&A–1 of § 54.4980B–8.

(d) The right to add new family members under this Q&A–5 is in addition to

the rights that newborn and adopted children of covered employees may have as qualified beneficiaries; see Q&A–1 in § 54.4980B–3.

[T.D. 8812, 64 FR 5180, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1852, Jan. 10, 2001]

§ 54.4980B–6 Electing COBRA continuation coverage.

The following questions-and-answers address the manner in which COBRA continuation coverage is elected:

Q–1: What is the election period and how long must it last?

A–1: (a) A group health plan can condition the availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the qualified beneficiary would lose coverage on account of the qualifying event. (See paragraph (c) of Q&A–1 of § 54.4980B–4 for the meaning of *lose coverage*.) The election period must not end before the date that is 60 days after the later of—

(1) The date the qualified beneficiary would lose coverage on account of the qualifying event; or

(2) The date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage.

(b) An election is considered to be made on the date it is sent to the plan administrator.

(c) The rules of this Q&A–1 are illustrated by the following example:

Example. (i) An unmarried employee without children who is receiving employer-paid coverage under a group health plan voluntarily terminates employment on June 1, 2001. The employee is not disabled at the time of the termination of employment nor at any time thereafter, and the plan does not provide for the extension of the required periods (as is permitted under paragraph (b) of Q&A–4 of § 54.4980B–7).

(ii) *Case 1:* If the plan provides that the employer-paid coverage ends immediately upon the termination of employment, the election period must begin not later than June 1, 2001, and must not end earlier than July 31, 2001. If notice of the right to elect COBRA continuation coverage is not provided to the employee until June 15, 2001, the election period must not end earlier than August 14, 2001.

(iii) *Case 2:* If the plan provides that the employer-paid coverage does not end until 6 months after the termination of employment, the employee does not lose coverage until December 1, 2001. The election period can therefore begin as late as December 1, 2001, and must not end before January 30, 2002.

(iv) *Case 3:* If employer-paid coverage for 6 months after the termination of employment is offered only to those qualified beneficiaries who waive COBRA continuation coverage, the employee loses coverage on June 1, 2001, so the election period is the same as in Case 1. The difference between Case 2 and Case 3 is that in Case 2 the employee can receive 6 months of employer-paid coverage and then elect to pay for up to an additional 12 months of COBRA continuation coverage, while in Case 3 the employee must choose between 6 months of employer-paid coverage and paying for up to 18 months of COBRA continuation coverage. In all three cases, COBRA continuation coverage need not be provided for more than 18 months after the termination of employment (see Q&A–4 of § 54.4980B–7), and in certain circumstances might be provided for a shorter period (see Q&A–1 of § 54.4980B–7).

Q–2: Is a covered employee or qualified beneficiary responsible for informing the plan administrator of the occurrence of a qualifying event?

A–2: (a) In general, the employer or plan administrator must determine when a qualifying event has occurred. However, each covered employee or qualified beneficiary is responsible for notifying the plan administrator of the occurrence of a qualifying event that is either a dependent child's ceasing to be a dependent child under the generally applicable requirements of the plan or a divorce or legal separation of a covered employee. The group health plan is not required to offer the qualified beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the plan administrator within 60 days after the later of—

(1) The date of the qualifying event; or

(2) The date the qualified beneficiary would lose coverage on account of the qualifying event.

(b) For purposes of this Q&A–2, if more than one qualified beneficiary would lose coverage on account of a divorce or legal separation of a covered employee, a timely notice of the divorce or legal separation that is provided by the covered employee or any one of those qualified beneficiaries will

be sufficient to preserve the election rights of all of the qualified beneficiaries.

Q–3: During the election period and before the qualified beneficiary has made an election, must coverage be provided?

A–3: (a) In general, each qualified beneficiary has until 60 days after the later of the date the qualifying event would cause her or him to lose coverage or the date notice is provided to the qualified beneficiary of her or his right to elect COBRA continuation coverage to decide whether to elect COBRA continuation coverage. If the election is made during that period, coverage must be provided from the date that coverage would otherwise have been lost (but see Q&A–4 of this section). This can be accomplished as described in paragraph (b) or (c) of this Q&A–3.

(b) In the case of an indemnity or reimbursement arrangement, the employer or employee organization can provide for plan coverage during the election period or, if the plan allows retroactive reinstatement, the employer or employee organization can terminate the coverage of the qualified beneficiary and reinstate her or him when the election (and, if applicable, payment for the coverage) is made. Claims incurred by a qualified beneficiary during the election period do not have to be paid before the election (and, if applicable, payment for the coverage) is made. If a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary during the election period, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights during the election period. For example, if the plan provides coverage during the election period but cancels coverage retroactively if COBRA continuation coverage is not elected, then the plan must inform a provider that a qualified beneficiary for whom coverage has not been elected is covered but that the coverage is subject to retroactive termination. Similarly, if the plan cancels coverage but then retroactively reinstates it once COBRA continuation coverage is elected, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the date coverage was lost if COBRA continuation coverage is elected. (See paragraph (c) of Q&A–5 in § 54.4980B–8 for similar rules that a plan must follow in confirming coverage during a period when the plan has not received payment but that is still within the grace period for a qualified beneficiary for whom COBRA continuation coverage has been elected.)

(c)(1) In the case of a group health plan that provides health services (such as a health maintenance organization or a walk-in clinic), the plan can require with respect to a qualified beneficiary who has not elected and paid for COBRA continuation coverage that the qualified beneficiary choose between—

(i) Electing and paying for the coverage; or

(ii) Paying the reasonable and customary charge for the plan's services, but only if a qualified beneficiary who chooses to pay for the services will be reimbursed for that payment within 30 days after the election of COBRA continuation coverage (and, if applicable, the payment of any balance due for the coverage).

(2) In the alternative, the plan can provide continued coverage and treat the qualified beneficiary's use of the facility as a constructive election. In such a case, the qualified beneficiary is obligated to pay any applicable charge for the coverage, but only if the qualified beneficiary is informed that use of the facility will be a constructive election before using the facility.

Q–4: Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

A–4: If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver of COBRA continuation coverage is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers

and revocations of waivers are considered made on the date they are sent to the employer, employee organization, or plan administrator, as applicable.

Q–5: Can an employer or employee organization withhold money or other benefits owed to a qualified beneficiary until the qualified beneficiary either waives COBRA continuation coverage, elects and pays for such coverage, or allows the election period to expire?

A–5: No. An employer, and an employee organization, must not withhold anything to which a qualified beneficiary is otherwise entitled (by operation of law or other agreement) in order to compel payment for COBRA continuation coverage or to coerce the qualified beneficiary to give up rights to COBRA continuation coverage (including the right to use the full election period to decide whether to elect such coverage). Such a withholding constitutes a failure to comply with the COBRA continuation coverage requirements. Furthermore, any purported waiver obtained by means of such a withholding is invalid.

Q–6: Can each qualified beneficiary make an independent election under COBRA?

A–6: Yes. Each qualified beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. If the plan allows similarly situated active employees with respect to whom a qualifying event has not occurred to choose among several options during an open enrollment period (for example, to switch to another group health plan or to another benefit package under the same group health plan), then each qualified beneficiary must also be offered an independent election to choose during an open enrollment period among the options made available to similarly situated active employees with respect to whom a qualifying event has not occurred. If a qualified beneficiary who is either a covered employee or the spouse of a covered employee elects COBRA continuation coverage and the election does not specify whether the election is for self-only coverage, the election is deemed to include an election of COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to that qualifying event. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a qualified beneficiary who is incapacitated or dies can be made by the legal representative of the qualified beneficiary or the qualified beneficiary's estate, as determined under applicable state law, or by the spouse of the qualified beneficiary. (See also Q&A–5 of § 54.4980B–7 relating to the independent right of each qualified beneficiary with respect to the same qualifying event to receive COBRA continuation coverage during the disability extension.) The rules of this Q&A–6 are illustrated by the following examples; in each example each group health plan is subject to COBRA:

Example 1. (i) Employee *H* and *H*'s spouse are covered under a group health plan immediately before *H*'s termination of employment (for reasons other than gross misconduct). Coverage under the plan will end as a result of the termination of employment.

(ii) Upon *H*'s termination of employment, both *H* and *H*'s spouse are qualified beneficiaries and each must be allowed to elect COBRA continuation coverage. Thus, *H* might elect COBRA continuation coverage while the spouse declines to elect such coverage, or *H* might elect COBRA continuation coverage for both of them. In contrast, *H* cannot decline COBRA continuation coverage on behalf of *H*'s spouse. Thus, if *H* does not elect COBRA continuation coverage on behalf of the spouse, the spouse must still be allowed to elect COBRA continuation coverage.

Example 2. (i) An employer maintains a group health plan under which all employees receive employer-paid coverage. Employees can arrange to cover their families by paying an additional amount. The employer also maintains a cafeteria plan, under which one of the options is to pay part or all of the employee share of the cost for family coverage under the group health plan. Thus, an employee might pay for family coverage under the group health plan partly with before-tax dollars and partly with after-tax dollars.

(ii) If an employee's family is receiving coverage under the group health plan when a qualifying event occurs, each of the qualified beneficiaries must be offered an opportunity to elect COBRA continuation coverage, regardless of how that qualified beneficiary's

coverage was paid for before the qualifying event.

[T.D. 8812, 64 FR 5182, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1853, Jan. 10, 2001]

§ 54.4980B–7 Duration of COBRA continuation coverage.

The following questions-and-answers address the duration of COBRA continuation coverage:

Q–1: How long must COBRA continuation coverage be made available to a qualified beneficiary?

A–1: (a) Except for an interruption of coverage in connection with a waiver, as described in Q&A–4 of § 54.4980B–6, COBRA continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates—

(1) The last day of the maximum coverage period (see Q&A–4 of this section);

(2) The first day for which timely payment is not made to the plan with respect to the qualified beneficiary (see Q&A–5 in § 54.4980B–8);

(3) The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;

(4) The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan, as described in Q&A–2 of this section;

(5) The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits, as described in Q&A–3 of this section; and

(6) In the case of a qualified beneficiary entitled to a disability extension (see Q&A–5 of this section), the later of—

(i) Either 29 months after the date of the qualifying event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act (42 U.S.C. 401–433 or 1381–1385) that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's being entitled to the disability extension is no longer disabled, whichever is earlier; or

(ii) The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.

(b) However, a group health plan can terminate for cause the coverage of a qualified beneficiary receiving COBRA continuation coverage on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries. For example, if a group health plan terminates the coverage of active employees for the submission of a fraudulent claim, then the coverage of a qualified beneficiary can also be terminated for the submission of a fraudulent claim. Notwithstanding the preceding two sentences, the coverage of a qualified beneficiary can be terminated for failure to make timely payment to the plan only if payment is not timely under the rules of Q&A–5 in § 54.4980B–8.

(c) In the case of an individual who is not a qualified beneficiary and who is receiving coverage under a group health plan solely because of the individual's relationship to a qualified beneficiary, if the plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases under this section, the plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q–2: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to coverage under another group health plan?

A–2: (a) If a qualified beneficiary first becomes covered under another group health plan (including for this purpose any group health plan of a governmental employer or employee organization) after the date on which COBRA continuation coverage is elected for the qualified beneficiary and the other coverage satisfies the requirements of paragraphs (b), (c), and (d) of this Q&A–2, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary first becomes covered under the other group health plan (even if the other coverage is less valuable to the qualified beneficiary). By contrast, if a qualified beneficiary first becomes covered under another

group health plan on or before the date on which COBRA continuation coverage is elected, then the other coverage cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) The requirement of this paragraph (b) is satisfied if the qualified beneficiary is actually covered, rather than merely eligible to be covered, under the other group health plan.

(c) The requirement of this paragraph (c) is satisfied if the other group health plan is a plan that is not maintained by the employer or employee organization that maintains the plan under which COBRA continuation coverage must otherwise be made available.

(d) The requirement of this paragraph (d) is satisfied if the other group health plan does not contain any exclusion or limitation with respect to any preexisting condition of the qualified beneficiary (other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified beneficiary by reason of the provisions in section 9801 (relating to limitations on preexisting condition exclusion periods in group health plans)).

(e) The rules of this Q&A–2 are illustrated by the following examples:

Example 1. (i) Employer *X* maintains a group health plan subject to COBRA. *C* is an employee covered under the plan. *C* is also covered under a group health plan maintained by Employer *Y*, the employer of *C*'s spouse. *C* terminates employment (for reasons other than gross misconduct), and the termination of employment causes *C* to lose coverage under *X*'s plan (and, thus, is a qualifying event). *C* elects to receive COBRA continuation coverage under *X*'s plan.

(ii) Under these facts, *X*'s plan cannot terminate *C*'s COBRA continuation coverage on the basis of *C*'s coverage under *Y*'s plan.

Example 2. (i) Employer *W* maintains a group health plan subject to COBRA. *D* is an employee covered under the plan. *D* terminates employment (for reasons other than gross misconduct), and the termination of employment causes *D* to lose coverage under *W*'s plan (and, thus, is a qualifying event). *D* elects to receive COBRA continuation coverage under *W*'s plan. Later *D* becomes employed by Employer *V* and is covered under *V*'s group health plan. *D*'s coverage under *V*'s plan is not subject to any exclusion or limitation with respect to any preexisting condition of *D*.

(ii) Under these facts, *W* can terminate *D*'s COBRA continuation coverage on the date *D* becomes covered under *V*'s plan.

Example 3. (i) The facts are the same as in *Example 2*, except that *D* becomes employed by *V* and becomes covered under *V*'s group health plan before *D* elects COBRA continuation coverage under *W*'s plan.

(ii) Because the termination of employment is a qualifying event, *D* must be offered COBRA continuation coverage under *W*'s plan, and *W* is not permitted to terminate *D*'s COBRA continuation coverage on account of *D*'s coverage under *V*'s plan because *D* first became covered under *V*'s plan before COBRA continuation coverage was elected for *D*.

Q–3: When may a plan terminate a qualified beneficiary's COBRA continuation coverage due to the qualified beneficiary's entitlement to Medicare benefits?

A–3: (a) If a qualified beneficiary first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) after the date on which COBRA continuation coverage is elected for the qualified beneficiary, then the plan may terminate the qualified beneficiary's COBRA continuation coverage upon the date on which the qualified beneficiary becomes so entitled. By contrast, if a qualified beneficiary first becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.

(b) A qualified beneficiary becomes entitled to Medicare benefits upon the effective date of enrollment in either part A or B, whichever occurs earlier. Thus, merely being eligible to enroll in Medicare does not constitute being entitled to Medicare benefits.

Q–4: When does the maximum coverage period end?

A–4: (a) Except as otherwise provided in this Q&A–4, the maximum coverage period ends 36 months after the qualifying event. The maximum coverage period for a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage is the maximum coverage period for the qualifying event giving rise to the

period of COBRA continuation coverage during which the child was born or placed for adoption. Paragraph (b) of this Q&A–4 describes the starting point from which the end of the maximum coverage period is measured. The date that the maximum coverage period ends is described in paragraph (c) of this Q&A–4 in a case where the qualifying event is a termination of employment or reduction of hours of employment, in paragraph (d) of this Q&A–4 in a case where a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, and in paragraph (e) of this Q&A–4 in the case of a qualifying event that is the bankruptcy of the employer. See Q&A–8 of § 54.4980B–2 for limitations that apply to certain health flexible spending arrangements. See also Q&A–6 of this section in the case of multiple qualifying events. Nothing in §§ 54.4980B–1 through 54.4980B–10 prohibits a group health plan from providing coverage that continues beyond the end of the maximum coverage period.

(b)(1) The end of the maximum coverage period is measured from the date of the qualifying event even if the qualifying event does not result in a loss of coverage under the plan until a later date. If, however, coverage under the plan is lost at a later date and the plan provides for the extension of the required periods, then the maximum coverage period is measured from the date when coverage is lost. A plan provides for the extension of the required periods if it provides both—

(i) That the 30-day notice period (during which the employer is required to notify the plan administrator of the occurrence of certain qualifying events such as the death of the covered employee or the termination of employment or reduction of hours of employment of the covered employee) begins on the date of the loss of coverage rather than on the date of the qualifying event; and

(ii) That the end of the maximum coverage period is measured from the date of the loss of coverage rather than from the date of the qualifying event.

(2) In the case of a plan that provides for the extension of the required periods, whenever the rules of §§ 54.4980B–1 through 54.4980B–10 refer to the measurement of a period from the date of the qualifying event, those rules apply in such a case by measuring the period instead from the date of the loss of coverage.

(c) In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the qualifying event if there is no disability extension, and 29 months after the qualifying event if there is a disability extension. See Q&A–5 of this section for rules to determine if there is a disability extension. If there is a disability extension and the disabled qualified beneficiary is later determined to no longer be disabled, then a plan may terminate the COBRA continuation coverage of an affected qualified beneficiary before the end of the disability extension; see paragraph (a)(6) in Q&A–1 of this section.

(d)(1) If a covered employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395–1395ggg) before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered employee ends on the later of—

(i) 36 months after the date the covered employee became entitled to Medicare benefits; or

(ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.

(2) See paragraph (b) of Q&A–3 of this section regarding the determination of when a covered employee becomes entitled to Medicare benefits.

(e) In the case of a qualifying event that is the bankruptcy of the employer, the maximum coverage period for a qualified beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a qualified beneficiary who is the spouse, surviving spouse, or dependent

child of the retired covered employee ends on the earlier of—

(1) The date of the qualified beneficiary's death; or

(2) The date that is 36 months after the death of the retired covered employee.

Q–5: How does a qualified beneficiary become entitled to a disability extension?

A–5: (a) A qualified beneficiary becomes entitled to a disability extension if the requirements of paragraphs (b), (c), and (d) of this Q&A–5 are satisfied with respect to the qualified beneficiary. If the disability extension applies with respect to a qualifying event, it applies with respect to each qualified beneficiary entitled to COBRA continuation coverage because of that qualifying event. Thus, for example, the 29-month maximum coverage period applies to each qualified beneficiary who is not disabled as well as to the qualified beneficiary who is disabled, and it applies independently with respect to each of the qualified beneficiaries. See Q&A–1 in § 54.4980B–8, which permits a plan to require payment of an increased amount during the disability extension.

(b) The requirement of this paragraph (b) is satisfied if a qualifying event occurs that is a termination, or reduction of hours, of a covered employee's employment.

(c) The requirement of this paragraph (c) is satisfied if an individual (whether or not the covered employee) who is a qualified beneficiary in connection with the qualifying event described in paragraph (b) of this Q&A–5 is determined under Title II or XVI of the Social Security Act (42 U.S.C. 401–433 or 1381–1385) to have been disabled at any time during the first 60 days of COBRA continuation coverage. For this purpose, the period of the first 60 days of COBRA continuation coverage is measured from the date of the qualifying event described in paragraph (b) of this Q&A–5 (except that if a loss of coverage would occur at a later date in the absence of an election for COBRA continuation coverage and if the plan provides for the extension of the required periods (as described in paragraph (b) of Q&A–4 of this section) then the period of the first 60 days of COBRA continuation coverage is measured from the date on which the coverage would be lost). However, in the case of a qualified beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. For purposes of this paragraph (c), an individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.

(d) The requirement of this paragraph (d) is satisfied if any of the qualified beneficiaries affected by the qualifying event described in paragraph (b) of this Q&A–5 provides notice to the plan administrator of the disability determination on a date that is both within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period that applies to the qualifying event.

Q–6: Under what circumstances can the maximum coverage period be expanded?

A–6: (a) The maximum coverage period can be expanded if the requirements of Q&A–5 of this section (relating to the disability extension) or paragraph (b) of this Q&A–6 are satisfied.

(b) The requirements of this paragraph (b) are satisfied if a qualifying event that gives rise to an 18-month maximum coverage period (or a 29-month maximum coverage period in the case of a disability extension) is followed, within that 18-month period (or within that 29-month period, in the case of a disability extension), by a second qualifying event (for example, a death or a divorce) that gives rise to a 36-month maximum coverage period. (Thus, a termination of employment following a qualifying event that is a reduction of hours of employment cannot be a second qualifying event that

expands the maximum coverage period; the bankruptcy of an employer also cannot be a second qualifying event that expands the maximum coverage period.) In such a case, the original 18-month period (or 29-month period, in the case of a disability extension) is expanded to 36 months, but only for those individuals who were qualified beneficiaries under the group health plan in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event. No qualifying event (other than a qualifying event that is the bankruptcy of the employer) can give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event (or more than 36 months after the date of the loss of coverage, in the case of a plan that provides for the extension of the required periods; see paragraph (b) in Q&A–4 of this section). For example, if an employee covered by a group health plan that is subject to COBRA terminates employment (for reasons other than gross misconduct) on December 31, 2000, the termination is a qualifying event giving rise to a maximum coverage period that extends for 18 months to June 30, 2002. If the employee dies after the employee and the employee's spouse and dependent children have elected COBRA continuation coverage and on or before June 30, 2002, the spouse and dependent children (except anyone among them whose COBRA continuation coverage had already ended for some other reason) will be able to receive COBRA continuation coverage through December 31, 2003. See Q&A–8(b) of § 54.4980B–2 for a special rule that applies to certain health flexible spending arrangements.

Q–7: If health coverage is provided to a qualified beneficiary after a qualifying event without regard to COBRA continuation coverage (for example, as a result of state or local law, the Uniformed Services Employment and Reemployment Rights Act of 1994 (38 U.S.C. 4315), industry practice, a collective bargaining agreement, severance agreement, or plan procedure), will such alternative coverage extend the maximum coverage period?

A–7: (a) No. The end of the maximum coverage period is measured solely as described in Q&A–4 and Q&A–6 of this section, which is generally from the date of the qualifying event.

(b) If the alternative coverage does not satisfy all the requirements for COBRA continuation coverage, or if the amount that the group health plan requires to be paid for the alternative coverage is greater than the amount required to be paid by similarly situated nonCOBRA beneficiaries for the coverage that the qualified beneficiary can elect to receive as COBRA continuation coverage, the plan covering the qualified beneficiary immediately before the qualifying event must offer the qualified beneficiary receiving the alternative coverage the opportunity to elect COBRA continuation coverage. See Q&A–1 of § 54.4980B–6.

(c) If an individual rejects COBRA continuation coverage in favor of alternative coverage, then, at the expiration of the alternative coverage period, the individual need not be offered a COBRA election. However, if the individual receiving alternative coverage is a covered employee and the spouse or a dependent child of the individual would lose that alternative coverage as a result of a qualifying event (such as the death of the covered employee), the spouse or dependent child must be given an opportunity to elect to continue that alternative coverage, with a maximum coverage period of 36 months measured from the date of that qualifying event.

Q–8: Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

A–8: If a qualified beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period that ends on that expiration date, provide the qualified beneficiary the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA beneficiaries under the group health plan. If such a conversion

option is not otherwise generally available, it need not be made available to qualified beneficiaries.

[T.D. 8812, 64 FR 5184, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1853, Jan. 10, 2001]

§ 54.4980B–8 Paying for COBRA continuation coverage.

The following questions-and-answers address paying for COBRA continuation coverage:

Q–1: Can a group health plan require payment for COBRA continuation coverage?

A–1: (a) Yes. For any period of COBRA continuation coverage, a group health plan can require the payment of an amount that does not exceed 102 percent of the applicable premium for that period. (See paragraph (b) of this Q&A–1 for a rule permitting a plan to require payment of an increased amount due to the disability extension.) The applicable premium is defined in section 4980B(f)(4). A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary (see Q&A–1 of § 54.4980B–7). For the meaning of *timely payment,* see Q&A–5 of this section.

(b) A group health plan is permitted to require the payment of an amount that does not exceed 150 percent of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary (for example, whether single or family coverage) if the coverage would not be required to be made available in the absence of a disability extension. (See Q&A–5 of § 54.4980B–7 for rules to determine whether a qualified beneficiary is entitled to a disability extension.) A plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage to which a qualified beneficiary is entitled without regard to the disability extension. Thus, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event within the original 18-month maximum coverage period, then the plan is not permitted to require the payment of an amount that exceeds 102 percent of the applicable premium for any period of COBRA continuation coverage. By contrast, if a qualified beneficiary entitled to a disability extension experiences a second qualifying event after the end of the original 18-month maximum coverage period, then the plan may require the payment of an amount that is up to 150 percent of the applicable premium for the remainder of the period of COBRA continuation coverage (that is, from the beginning of the 19th month through the end of the 36th month) as long as the disabled qualified beneficiary is included in that coverage. The rules of this paragraph (b) are illustrated by the following examples; in each example the group health plan is subject to COBRA:

Example 1. (i) An employer maintains a group health plan. The plan determines the cost of covering individuals under the plan by reference to two categories, individual coverage and family coverage, and the applicable premium is determined for those two categories. An employee and members of the employee's family are covered under the plan. The employee experiences a qualifying event that is the termination of the employee's employment. The employee's family qualifies for the disability extension because of the disability of the employee's spouse. (Timely notice of the disability is provided to the plan administrator.) Timely payment of the amount required by the plan for COBRA continuation coverage for the family (which does not exceed 102 percent of the cost of family coverage under the plan) was made to the plan with respect to the employee's family for the first 18 months of COBRA continuation coverage, and the disabled spouse and the rest of the family continue to receive COBRA continuation coverage through the 29th month.

(ii) Under these facts, the plan may require payment of up to 150 percent of the applicable premium for family coverage in order for the family to receive COBRA continuation coverage from the 19th month through the 29th month. If the plan determined the cost of coverage by reference to three categories (such as employee, employee-plus-one-dependent, employee-plus-two-or-more-dependents) or more than three categories, instead of two categories, the plan could still require, from the 19th month through the 29th month of COBRA continuation coverage, the payment of 150 percent of the cost of coverage for the category of coverage that included the disabled spouse.

Example 2. (i) The facts are the same as in *Example 1,* except that only the covered employee elects and pays for the first 18 months of COBRA continuation coverage.

(ii) Even though the employee's disabled spouse does not elect or pay for COBRA continuation coverage, the employee satisfies the requirements for the disability extension to apply with respect to the employee's qualifying event. Under these facts, the plan may not require the payment of more than 102 percent of the applicable premium for individual coverage for the entire period of the employee's COBRA continuation coverage, including the period from the 19th month through the 29th month. If COBRA continuation coverage had been elected and paid for with respect to other nondisabled members of the employee's family, then the plan could not require the payment of more than 102 percent of the applicable premium for family coverage (or for any other appropriate category of coverage that might apply to that group of qualified beneficiaries under the plan, such as employee-plus-one-dependent or employee-plus-two-or-more-dependents) for those family members to continue their coverage from the 19th month through the 29th month.

(c) A group health plan does not fail to comply with section 9802(b) (which generally prohibits an individual from being charged, on the basis of health status, a higher premium than that charged for similarly situated individuals enrolled in the plan) with respect to a qualified beneficiary entitled to the disability extension merely because the plan requires payment of an amount permitted under paragraph (b) of this Q&A–1.

Q–2: When is the applicable premium determined and when can a group health plan increase the amount it requires to be paid for COBRA continuation coverage?

A–2: (a) The applicable premium for each determination period must be computed and fixed by a group health plan before the determination period begins. A determination period is any 12-month period selected by the plan, but it must be applied consistently from year to year. The determination period is a single period for any benefit package. Thus, each qualified beneficiary does not have a separate determination period beginning on the date (or anniversaries of the date) that COBRA continuation coverage begins for that qualified beneficiary.

(b) During a determination period, a plan can increase the amount it requires to be paid for a qualified beneficiary's COBRA continuation coverage only in the following three cases:

(1) The plan has previously charged less than the maximum amount permitted under Q&A–1 of this section and the increased amount required to be paid does not exceed the maximum amount permitted under Q&A–1 of this section;

(2) The increase occurs during the disability extension and the increased amount required to be paid does not exceed the maximum amount permitted under paragraph (b) of Q&A–1 of this section; or

(3) A qualified beneficiary changes the coverage being received (see paragraph (c) of this Q&A–2 for rules on how the amount the plan requires to be paid may or must change when a qualified beneficiary changes the coverage being received).

(c) If a plan allows similarly situated active employees who have not experienced a qualifying event to change the coverage they are receiving, then the plan must also allow each qualified beneficiary to change the coverage being received on the same terms as the similarly situated active employees. (See Q&A–4 in § 54.4980B–5.) If a qualified beneficiary changes coverage from one benefit package (or a group of benefit packages) to another benefit package (or another group of benefit packages), or adds or eliminates coverage for family members, then the following rules apply. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as family coverage, self-plus-one-dependent, or self-plus-two-or-more-dependents) for which the applicable premium is higher, then the plan may increase the amount that it requires to be paid for COBRA continuation coverage to an amount that does not exceed the amount permitted under Q&A–1 of this section as applied to the new coverage. If the change in coverage is to a benefit package, group of benefit packages, or coverage unit (such as individual or self-plus-one-dependent) for which the applicable premium is lower, then the plan cannot require the payment of an amount that exceeds the amount permitted under Q&A–1 of this section as applied to the new coverage.

Q–3: Must a plan allow payment for COBRA continuation coverage to be made in monthly installments?

A–3: Yes. A group health plan must allow payment for COBRA continuation coverage to be made in monthly installments. A group health plan is permitted to also allow the alternative of payment for COBRA continuation coverage being made at other intervals (for example, weekly, quarterly, or semiannually).

Q–4: Is a plan required to allow a qualified beneficiary to choose to have the first payment for COBRA continuation coverage applied prospectively only?

A–4: No. A plan is permitted to apply the first payment for COBRA continuation coverage to the period of coverage beginning immediately after the date on which coverage under the plan would have been lost on account of the qualifying event. Of course, if the group health plan allows a qualified beneficiary to waive COBRA continuation coverage for any period before electing to receive COBRA continuation coverage, the first payment is not applied to the period of the waiver.

Q–5: What is timely payment for COBRA continuation coverage?

A–5: (a) Except as provided in this paragraph (a) or in paragraph (b) or (d) of this Q&A–5, timely payment for a period of COBRA continuation coverage under a group health plan means payment that is made to the plan by the date that is 30 days after the first day of that period. Payment that is made to the plan by a later date is also considered timely payment if either—

(1) Under the terms of the plan, covered employees or qualified beneficiaries are allowed until that later date to pay for their coverage for the period; or

(2) Under the terms of an arrangement between the employer or employee organization and an insurance company, health maintenance organization, or other entity that provides plan benefits on the employer's or employee organization's behalf, the employer or employee organization is allowed until that later date to pay for coverage of similarly situated nonCOBRA beneficiaries for the period.

(b) Notwithstanding paragraph (a) of this Q&A–5, a plan cannot require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary.

(c) If, after COBRA continuation coverage has been elected for a qualified beneficiary, a provider of health care (such as a physician, hospital, or pharmacy) contacts the plan to confirm coverage of a qualified beneficiary for a period for which the plan has not yet received payment, the plan must give a complete response to the health care provider about the qualified beneficiary's COBRA continuation coverage rights, if any, described in paragraphs (a), (b), and (d) of this Q&A–5. For example, if the plan provides coverage during the 30- and 45-day grace periods described in paragraphs (a) and (b) of this Q&A–5 but cancels coverage retroactively if payment is not made by the end of the applicable grace period, then the plan must inform a provider with respect to a qualified beneficiary for whom payment has not been received that the qualified beneficiary is covered but that the coverage is subject to retroactive termination if timely payment is not made. Similarly, if the plan cancels coverage if it has not received payment by the first day of a period of coverage but retroactively reinstates coverage if payment is made by the end of the grace period for that period of coverage, then the plan must inform the provider that the qualified beneficiary currently does not have coverage but will have coverage retroactively to the first date of the period if timely payment is made. (See paragraph (b) of Q&A–3 in § 54.4980B–6 for similar rules that the plan must follow in confirming coverage during the election period.)

(d) If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the plan's requirement for the amount that must be paid, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. For this purpose, as a safe harbor, 30 days after the date the notice is provided is deemed to be a reasonable

period of time. An amount is not significantly less than the amount the plan requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:

(1) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Bulletin (see § 601.601(d)(2)(ii) of this chapter)); or

(2) 10 percent of the amount the plan requires to be paid.

(e) Payment is considered made on the date on which it is sent to the plan.

[T.D. 8812, 64 FR 5186, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1854, Jan. 10, 2001]

§ 54.4980B–9 Business reorganizations and employer withdrawals from multiemployer plans.

The following questions-and-answers address who has the obligation to make COBRA continuation coverage available to affected qualified beneficiaries in the context of business reorganizations and employer withdrawals from multiemployer plans:

Q–1: For purposes of this section, what are a business reorganization, a stock sale, and an asset sale?

A–1: For purposes of this section:

(a) A *business reorganization* is a stock sale or an asset sale.

(b) A *stock sale* is a transfer of stock in a corporation that causes the corporation to become a different employer or a member of a different employer. (See Q&A–2 of § 54.4980B–2, which defines *employer* to include all members of a controlled group of corporations.) Thus, for example, a sale or distribution of stock in a corporation that causes the corporation to cease to be a member of one controlled group of corporations, whether or not it becomes a member of another controlled group of corporations, is a stock sale.

(c) An *asset sale* is a transfer of substantial assets, such as a plant or division or substantially all the assets of a trade or business.

(d) The rules of § 1.414(b)–1 of this chapter apply in determining what constitutes a controlled group of corporations, and the rules of §§ 1.414(c)–1 through 1.414(c)–5 of this chapter apply in determining what constitutes a group of trades or businesses under common control.

Q–2: In the case of a stock sale, what are the selling group, the acquired organization, and the buying group?

A–2: In the case of a stock sale—

(a) The *selling group* is the controlled group of corporations, or the group of trades or businesses under common control, of which a corporation ceases to be a member as a result of the stock sale;

(b) The *acquired organization* is the corporation that ceases to be a member of the selling group as a result of the stock sale; and

(c) The *buying group* is the controlled group of corporations, or the group of trades or businesses under common control, of which the acquired organization becomes a member as a result of the stock sale. If the acquired organization does not become a member of such a group, the *buying group* is the acquired organization.

Q–3: In the case of an asset sale, what are the selling group and the buying group?

A–3: In the case of an asset sale—

(a) The *selling group* is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is selling the assets; and

(b) The *buying group* is the controlled group of corporations or the group of trades or businesses under common control that includes the corporation or other trade or business that is buying the assets.

Q–4: Who is an M&A qualified beneficiary?

A–4: (a) Asset sales: In the case of an asset sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was associated with the assets being sold.

(b) Stock sales: In the case of a stock sale, an individual is an M&A qualified beneficiary if the individual is a qualified beneficiary whose qualifying event occurred prior to or in connection with

the sale and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the acquired organization.

(c) In the case of a qualified beneficiary who has experienced more than one qualifying event with respect to her or his current right to COBRA continuation coverage, the qualifying event referred to in paragraphs (a) and (b) of this Q&A–4 is the first qualifying event.

Q–5: In the case of a stock sale, is the sale a qualifying event with respect to a covered employee who is employed by the acquired organization before the sale and who continues to be employed by the acquired organization after the sale, or with respect to the spouse or dependent children of such a covered employee?

A–5: No. A covered employee who continues to be employed by the acquired organization after the sale does not experience a termination of employment as a result of the sale. Accordingly, the sale is not a qualifying event with respect to the covered employee, or with respect to the covered employee's spouse or dependent children, regardless of whether they are provided with group health coverage after the sale, and neither the covered employee, nor the covered employee's spouse or dependent children, become qualified beneficiaries as a result of the sale.

Q–6: In the case of an asset sale, is the sale a qualifying event with respect to a covered employee whose employment immediately before the sale was associated with the purchased assets, or with respect to the spouse or dependent children of such a covered employee who are covered under a group health plan of the selling group immediately before the sale?

A–6: (a) Yes, unless—

(1) The buying group is a successor employer under paragraph (c) of Q&A–8 of this section or Q&A–2 of § 54.4980B–2, and the covered employee is employed by the buying group immediately after the sale; or

(2) The covered employee (or the spouse or any dependent child of the covered employee) does not lose coverage (within the meaning of paragraph (c) in Q&A–1 of § 54.4980B-4) under a group health plan of the selling group after the sale.

(b) Unless the conditions in paragraph (a)(1) or (2) of this Q&A–6 are satisfied, such a covered employee experiences a termination of employment with the selling group as a result of the asset sale, regardless of whether the covered employee is employed by the buying group or whether the covered employee's employment is associated with the purchased assets after the sale. Accordingly, the covered employee, and the spouse and dependent children of the covered employee who lose coverage under a plan of the selling group in connection with the sale, are M&A qualified beneficiaries in connection with the sale.

Q–7: In a business reorganization, are the buying group and the selling group permitted to allocate by contract the responsibility to make COBRA continuation coverage available to M&A qualified beneficiaries?

A–7: Yes. Nothing in this section prohibits a selling group and a buying group from allocating to one or the other of the parties in a purchase agreement the responsibility to provide the coverage required under §§ 54.4980B–1 through 54.4980B–10. However, if and to the extent that the party assigned this responsibility under the terms of the contract fails to perform, the party who has the obligation under Q&A–8 of this section to make COBRA continuation coverage available to M&A qualified beneficiaries continues to have that obligation.

Q–8: Which group health plan has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries in a business reorganization?

A–8: (a) In the case of a business reorganization (whether a stock sale or an asset sale), so long as the selling group maintains a group health plan after the sale, a group health plan maintained by the selling group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that sale. This Q&A–8 prescribes rules for cases in

which the selling group ceases to provide any group health plan to any employee in connection with the sale. Paragraph (b) of this Q&A–8 contains these rules for stock sales, and paragraph (c) of this Q&A–8 contains these rules for asset sales. Neither a stock sale nor an asset sale has any effect on the COBRA continuation coverage requirements applicable to any group health plan for any period before the sale.

(b)(1) In the case of a stock sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that stock sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in § 54.4980B–7, relating to the duration of COBRA continuation coverage)—

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the stock sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the stock sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the stock sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(c)(1) In the case of an asset sale, if the selling group ceases to provide any group health plan to any employee in connection with the sale and if the buying group continues the business operations associated with the assets purchased from the selling group without interruption or substantial change, then the buying group is a successor employer to the selling group in connection with that asset sale. A buying group does not fail to be a successor employer in connection with an asset sale merely because the asset sale takes place in connection with a proceeding in bankruptcy under Title 11 of the United States Code. If the buying group is a successor employer, a group health plan maintained by the buying group has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to that asset sale. A group health plan of the buying group has this obligation beginning on the later of the following two dates and continuing as long as the buying group continues to maintain a group health plan (but subject to the rules in § 54.4980B–7, relating to the duration of COBRA continuation coverage)—

(i) The date the selling group ceases to provide any group health plan to any employee; or

(ii) The date of the asset sale.

(2) The determination of whether the selling group's cessation of providing any group health plan to any employee is in connection with the asset sale is based on all of the relevant facts and circumstances. A group health plan of the buying group does not, as a result of the asset sale, have an obligation to make COBRA continuation coverage available to those qualified beneficiaries of the selling group who are not M&A qualified beneficiaries with respect to that sale.

(d) The rules of Q&A–1 through Q&A–7 of this section and this Q&A–8 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Stock Sale Examples

Example 1. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 48 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 15 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other 33 qualified beneficiaries had qualifying events in connection with a covered

employee whose last employment before the qualifying event was with either *A* or *B*.)

(ii) Under these facts, *S*'s plan continues to have the obligation to make COBRA continuation coverage available to the 15 M&A qualified beneficiaries under *S*'s plan after the sale of *C* to *P*. The employees who continue in employment with *C* do not experience a qualifying event by virtue of *P*'s acquisition of *C*. If they experience a qualifying event after the sale, then the group health plan of *P* has the obligation to make COBRA continuation coverage available to them.

Example 2. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Each of *A*, *B*, and *C* maintains a group health plan for its employees (and their families). Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. As of June 30, 2002, there are 14 qualified beneficiaries receiving COBRA continuation coverage under *C*'s plan. *C* continues to employ all of its employees and continues to maintain its group health plan after being acquired by *P* on July 1, 2002.

(ii) Under these facts, *C* is an acquired organization and the 14 qualified beneficiaries under *C*'s plan are M&A qualified beneficiaries. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. *S* and *P* could negotiate to have *C*'s plan continue to make COBRA continuation coverage available to the 14 M&A qualified beneficiaries. In such a case, neither *A*'s plan nor *B*'s plan would make COBRA continuation coverage available to the 14 M&A qualified beneficiaries unless *C*'s plan failed to fulfill its contractual responsibility to make COBRA continuation coverage available to the M&A qualified beneficiaries. *C*'s employees (and their spouses and dependent children) do not experience a qualifying event in connection with *P*'s acquisition of *C*, and consequently no plan maintained by either *P* or *S* has any obligation to make COBRA continuation coverage available to *C*'s employees (or their spouses or dependent children) in connection with the transfer of stock in *C* from *S* to *P*.

Example 3. (i) The facts are the same as in *Example 2*, except that *C* ceases to employ two employees on June 30, 2002, and those two employees never become covered under *P*'s plan.

(ii) Under these facts, the two employees experience a qualifying event on June 30, 2002 because their termination of employment causes a loss of group health coverage. A group health plan of *S* (that is, either the plan maintained by *A* or the plan maintained by *B*) has the obligation to make COBRA continuation coverage available to the two employees (and to any spouse or dependent child of the two employees who loses coverage under *C*'s plan in connection with the termination of employment of the two employees) because they are M&A qualified beneficiaries with respect to the sale of *C*.

Example 4. (i) Selling Group *S* consists of three corporations, *A*, *B*, and *C*. Buying Group *P* consists of two corporations, *D* and *E*. *P* enters into a contract to purchase all of the stock of *C* from *S* effective July 1, 2002. Before the sale of *C*, *S* maintains a single group health plan for the employees of *A*, *B*, and *C* (and their families). *P* maintains a single group health plan for the employees of *D* and *E* (and their families). Effective July 1, 2002, the employees of *C* (and their families) become covered under *P*'s plan. On June 30, 2002, there are 25 qualified beneficiaries receiving COBRA continuation coverage under *S*'s plan, 20 of whom are M&A qualified beneficiaries with respect to the sale of *C*. (The other five qualified beneficiaries had qualifying events in connection with a covered employee whose last employment before the qualifying event was with either *A* or *B*.) S terminates its group health plan effective June 30, 2002 and begins to liquidate the assets of *A* and *B* and to lay off the employees of *A* and *B*.

(ii) Under these facts, *S* ceases to provide a group health plan to any employee in connection with the sale of *C* to *P*. Thus, beginning July 1, 2002 *P*'s plan has the obligation to make COBRA continuation coverage available to the 20 M&A qualified beneficiaries, but *P* is not obligated to make COBRA continuation coverage available to the other 5 qualified beneficiaries with respect to *S*'s plan as of June 30, 2002 or to any of the employees of *A* or *B* whose employment is terminated by *S* (or to any of those employees' spouses or dependent children).

Asset Sale Examples

Example 5. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells the assets of one of its divisions to Buying Group *P*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan. Immediately before the sale, there are two qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These two qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, a group health plan of *S* retains the obligation

to make COBRA continuation coverage available to these two M&A qualified beneficiaries. In addition, the one employee *P* does not hire as well as all of the employees *P* hires (and the spouses and dependent children of these employees) who were covered under a group health plan of *S* on the day before the sale are M&A qualified beneficiaries with respect to the sale. A group health plan of *S* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

Example 6. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P,* and *S* ceases to provide any group health plan to any employee on the date of the sale. *P* hires all but one of *S*'s employees on the date of the asset sale by *S,* gives those employees the same positions that they had with *S* before the sale, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. Immediately before the sale, there are 10 qualified beneficiaries receiving COBRA continuation coverage under a group health plan of *S* whose qualifying events occurred in connection with a covered employee whose last employment prior to the qualifying event was associated with the assets sold to *P*.

(ii) These 10 qualified beneficiaries are M&A qualified beneficiaries with respect to the asset sale to *P*. Under these facts, *P* is a successor employer described in paragraph (c) of this Q&A–8. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to these 10 M&A qualified beneficiaries.

(iii) The one employee that *P* does not hire and the family members of that employee are also M&A qualified beneficiaries with respect to the sale. A group health plan of *P* also has the obligation to make COBRA continuation coverage available to these M&A qualified beneficiaries.

(iv) The employees who continue in employment in connection with the asset sale (and their family members) and who were covered under a group health plan of *S* on the day before the sale are not M&A qualified beneficiaries because *P* is a successor employer to *S* in connection with the asset sale. Thus, no group health plan of *P* has any obligation to make COBRA continuation coverage available to these continuing employees with respect to the qualifying event that resulted from their losing coverage under *S*'s plan in connection with the asset sale.

Example 7. (i) Selling Group *S* provides group health plan coverage to employees at each of its two operating divisions. *S* sells the assets of one of its divisions to Buying Group *P1*. Under the terms of the group health plan covering the employees at the division being sold, their coverage will end on the date of the sale. *P1* hires all but one of those employees, gives them the same positions that they had with *S* before the sale, and provides them with coverage under a group health plan.

(ii) Under these facts, a group health plan of *S* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale to *P1*. (If an M&A qualified beneficiary first became covered under *P1*'s plan after electing COBRA continuation coverage under *S*'s plan, then *S*'s plan could terminate the COBRA continuation coverage once the M&A qualified beneficiary became covered under *P1*'s plan, provided that the remaining conditions of Q&A–2 of § 54.4980B–7 were satisfied.)

(iii) Several months after the sale to *P1, S* sells the assets of its remaining division to Buying Group *P2,* and *S* ceases to provide any group health plan to any employee on the date of that sale. Thus, under Q&A–1 of § 54.4980B–7, *S* ceases to have an obligation to make COBRA continuation coverage available to any qualified beneficiary on the date of the sale to *P2*. *P1* and *P2* are unrelated organizations.

(iv) Even if it was foreseeable that *S* would sell its remaining division to an unrelated third party after the sale to *P1,* under these facts the cessation of *S* to provide any group health plan to any employee on the date of the sale to *P2* is not in connection with the asset sale to *P1*. Thus, even after the date *S* ceases to provide any group health plan to any employee, no group health plan of *P1* has any obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. If *P2* is a successor employer under the rules of paragraph (c) of this Q&A–8 and maintains one or more group health plans after the sale, then a group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P2* by *S* (but in such a case employees of *S* before the sale who continued working for *P2* after the sale would not be M&A qualified beneficiaries). However, even in such a case, no group health plan of *P2* would have an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1* by *S*. Thus, under these facts, after *S* has ceased to provide any group health plan to any employee, no plan has an obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the asset sale to *P1*.

Example 8. (i) Selling Group *S* provides group health plan coverage to employees at each of its operating divisions. *S* sells substantially all of the assets of all of its divisions to Buying Group *P*. *P* hires most of *S*'s employees on the date of the purchase of *S*'s

assets, retains those employees in the same positions that they had with *S* before the purchase, and continues the business operations of those divisions without substantial change or interruption. *P* provides these employees with coverage under a group health plan. *S* continues to employ a few employees for the principal purpose of winding up the affairs of *S* in preparation for liquidation. *S* continues to provide coverage under a group health plan to these few remaining employees for several weeks after the date of the sale and then ceases to provide any group health plan to any employee.

(ii) Under these facts, the cessation by *S* to provide any group health plan to any employee is in connection with the asset sale to *P*. Because of this, and because *P* continued the business operations associated with those assets without substantial change or interruption, *P* is a successor employer to *S* with respect to the asset sale. Thus, a group health plan of *P* has the obligation to make COBRA continuation coverage available to M&A qualified beneficiaries with respect to the sale beginning on the date that *S* ceases to provide any group health plan to any employee. (A group health plan of *S* retains this obligation for the several weeks after the date of the sale until *S* ceases to provide any group health plan to any employee.)

Q–9: Can the cessation of contributions by an employer to a multiemployer group health plan be a qualifying event?

A–9: The cessation of contributions by an employer to a multiemployer group health plan is not itself a qualifying event, even though the cessation of contributions may cause current employees (and their spouses and dependent children) to lose coverage under the multiemployer plan. An event coinciding with the employer's cessation of contributions (such as a reduction of hours of employment in the case of striking employees) will constitute a qualifying event if it otherwise satisfies the requirements of Q&A–1 of § 54.4980B–4.

Q–10: If an employer stops contributing to a multiemployer group health plan, does the multiemployer plan have the obligation to make COBRA continuation coverage available to a qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer that has stopped contributing to the multiemployer plan?

A–10: (a) In general, yes. (See Q&A–3 of § 54.4980B–2 for a definition of *multiemployer plan*.) If, however, the employer that stops contributing to the multiemployer plan makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan with respect to) a class of the employer's employees formerly covered under the multiemployer plan, the plan maintained by the employer (or the other multiemployer plan), from that date forward, has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions and who is, or whose qualifying event occurred in connection with, a covered employee whose last employment prior to the qualifying event was with the employer.

(b) The rules of Q&A–9 of this section and this Q&A–10 are illustrated by the following examples; in each example, each group health plan is subject to COBRA:

Example 1. (i) Employer *Z* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Z* has been making contributions to *M*. *Z* experiences financial difficulties and stops making contributions to *M* but continues to employ all of the employees covered by the collective bargaining agreement. *Z*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Z* does not make group health plan coverage available to any of the employees covered by the collective bargaining agreement.

(ii) After *Z* stops contributing to *M*, *M* continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Z*. The loss of coverage under *M* for those employees of *Z* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 2. (i) The facts are the same as in *Example 1* except that *B*, one of the employees covered under *M* before *Z* stops contributing to *M*, is transferred into management. *Z* maintains a group health plan for managers and *B* becomes eligible for coverage under the plan on the day of *B*'s transfer.

(ii) Under these facts, *Z* does not make group health plan coverage available to a class of employees formerly covered under *M* after *B* becomes eligible under *Z*'s group health plan for managers. Accordingly, *M* continues to have the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Z*.

Example 3. (i) Employer *Y* employs two classes of employees—skilled and unskilled laborers—covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *Y* has been making contributions to *M*. *Y* stops making contributions to *M* but continues to employ all the employees covered by the collective bargaining agreement. *Y*'s cessation of contributions to *M* causes those employees (and their spouses and dependent children) to lose coverage under *M*. *Y* makes group health plan coverage available to the skilled laborers immediately after their coverage ceases under *M*, but *Y* does not make group health plan coverage available to any of the unskilled laborers.

(ii) Under these facts, because *Y* makes group health plan coverage available to a class of employees previously covered under *M* immediately after both classes of employees lose coverage under *M*, *Y* alone has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *Y*, regardless of whether the employment affiliation was as a skilled or unskilled laborer. However, the loss of coverage under *M* for those employees of *Y* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 4. (i) Employer *X* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *X* has been making contributions to *M*. *X* experiences financial difficulties and is forced into bankruptcy by its creditors. *X* continues to employ all of the employees covered by the collective bargaining agreement. *X* also continues to make contributions to *M* until the current collective bargaining agreement expires, on June 30, 2001, and then *X* stops making contributions to *M*. *X*'s employees (and their spouses and dependent children) lose coverage under *M* effective July 1, 2001. *X* does not enter into another collective bargaining agreement covering the class of employees covered by the expired collective bargaining agreement. Effective September 1, 2001, *X* establishes a group health plan covering the class of employees formerly covered by the collective bargaining agreement. The group health plan also covers their spouses and dependent children.

(ii) Under these facts, *M* has the obligation to make COBRA continuation coverage available from July 1, 2001 until August 31, 2001, and the group health plan established by *X* has the obligation to make COBRA continuation coverage available from September 1, 2001 until the obligation ends (see Q&A–1 of § 54.4980B–7) to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with *X*. The loss of coverage under *M* for those employees of *X* who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

Example 5. (i) Employer *W* employs a class of employees covered by a collective bargaining agreement and participating in multiemployer group health plan *M*. As required by the collective bargaining agreement, *W* has been making contributions to *M*. The employees covered by the collective bargaining agreement vote to decertify their current employee representative effective January 1, 2002 and vote to certify a new employee representative effective the same date. As a consequence, on January 1, 2002 they cease to be covered under *M* and commence to be covered under multiemployer group health plan *N*.

(ii) Effective January 1, 2002, *N* has the obligation to make COBRA continuation coverage available to any qualified beneficiary who experienced a qualifying event that preceded or coincided with the cessation of contributions to *M* and whose coverage under *M* on the day before the qualifying event was due to an employment affiliation with W. The loss of coverage under *M* for those employees of W who continue in employment (and the loss of coverage for their spouses and dependent children) does not constitute a qualifying event.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980B–10 Interaction of FMLA and COBRA.

The following questions-and-answers address how the taking of leave under the Family and Medical Leave Act of 1993 (FMLA) (29 U.S.C. 2601–2619) affects the COBRA continuation coverage requirements:

Q–1: In what circumstances does a qualifying event occur if an employee does not return from leave taken under FMLA?

A–1: (a) The taking of leave under FMLA does not constitute a qualifying event. A qualifying event under Q&A–1 of § 54.4980B–4 occurs, however, if—

(1) An employee (or the spouse or a dependent child of the employee) is covered on the day before the first day of FMLA leave (or becomes covered during the FMLA leave) under a group health plan of the employee's employer;

(2) The employee does not return to employment with the employer at the end of the FMLA leave; and

(3) The employee (or the spouse or a dependent child of the employee) would, in the absence of COBRA continuation coverage, lose coverage under the group health plan before the end of the maximum coverage period.

(b) However, the satisfaction of the three conditions in paragraph (a) of this Q&A–1 does not constitute a qualifying event if the employer eliminates, on or before the last day of the employee's FMLA leave, coverage under a group health plan for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken FMLA leave.

Q–2: If a qualifying event described in Q&A–1 of this section occurs, when does it occur, and how is the maximum coverage period measured?

A–2: A qualifying event described in Q&A–1 of this section occurs on the last day of FMLA leave. (The determination of when FMLA leave ends is not made under the rules of this section. See the FMLA regulations, 29 CFR Part 825 (§§ 825.100–825.800).) The maximum coverage period (see Q&A–4 of § 54.4980B–7) is measured from the date of the qualifying event (that is, the last day of FMLA leave). If, however, coverage under the group health plan is lost at a later date and the plan provides for the extension of the required periods (see paragraph (b) of Q&A–4 of § 54.4980B–7), then the maximum coverage period is measured from the date when coverage is lost. The rules of this Q&A–2 are illustrated by the following examples:

Example 1. (i) Employee *B* is covered under the group health plan of Employer *X* on January 31, 2001. *B* takes FMLA leave beginning February 1, 2001. *B*'s last day of FMLA leave is 12 weeks later, on April 25, 2001, and *B* does not return to work with *X* at the end of the FMLA leave. If *B* does not elect COBRA continuation coverage, *B* will not be covered under the group health plan of *X* as of April 26, 2001.

(ii) *B* experiences a qualifying event on April 25, 2001, and the maximum coverage period is measured from that date. (This is the case even if, for part or all of the FMLA leave, *B* fails to pay the employee portion of premiums for coverage under the group health plan of *X* and is not covered under *X*'s plan. See Q&A–3 of this section.)

Example 2. (i) Employee *C* and *C*'s spouse are covered under the group health plan of Employer *Y* on August 15, 2001. *C* takes FMLA leave beginning August 16, 2001. *C* informs *Y* less than 12 weeks later, on September 28, 2001, that *C* will not be returning to work. Under the FMLA regulations, 29 CFR Part 825 (§§ 825.100–825.800), *C*'s last day of FMLA leave is September 28, 2001. *C* does not return to work with *Y* at the end of the FMLA leave. If *C* and *C*'s spouse do not elect COBRA continuation coverage, they will not be covered under the group health plan of *Y* as of September 29, 2001.

(ii) *C* and *C*'s spouse experience a qualifying event on September 28, 2001, and the maximum coverage period (generally 18 months) is measured from that date. (This is the case even if, for part or all of the FMLA leave, *C* fails to pay the employee portion of premiums for coverage under the group health plan of *Y* and *C* or *C*'s spouse is not covered under *Y*'s plan. See Q&A–3 of this section.)

Q–3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

A–3: No. Any lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a set of circumstances constitutes a qualifying event under Q&A–1 of this

section or when such a qualifying event occurs under Q&A–2 of this section.

Q–4: Is the application of the rules in Q&A–1 through Q&A–3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

A–4: No. Any state or local law that requires coverage under a group health plan to be maintained during a leave of absence for a period longer than that required under FMLA (for example, for 16 weeks of leave rather than for the 12 weeks required under FMLA) is disregarded for purposes of determining when a qualifying event occurs under Q&A–1 through Q&A–3 of this section.

Q–5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

A–5: No. The U.S. Department of Labor has published rules describing the circumstances in which an employer may recover premiums it pays to maintain coverage, including family coverage, under a group health plan during FMLA leave from an employee who fails to return from leave. See 29 CFR 825.213. Even if recovery of premiums is permitted under 29 CFR 825.213, the right to COBRA continuation coverage cannot be conditioned upon the employee's reimbursement of the employer for premiums the employer paid to maintain coverage under a group health plan during FMLA leave.

[T.D. 8928, 66 FR 1855, Jan. 10, 2001]

§ 54.4980D–1 Requirement of return and time for filing of the excise tax under section 4980D.

Q–1: If a person is liable for the excise tax under section 4980D, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–1: (a) *In general. See* §§ 54.6011–2 and 54.6151–1.

(b) *Due date for filing of return by employers. See* § 54.6071–1(b)(1).

(c) *Due date for filing of return by multiemployer plans or multiple employer health plans. See* § 54.6071–1(b)(2).

(d) *Effective/applicability date.* In the case of an employer or other person mentioned in paragraph (b) of this Q & A–1, the rules in this Q & A–1 are effective for taxable years beginning on or after January 1, 2010. In the case of a plan mentioned in paragraph (c) of this Q & A–1, the rules in this Q & A–1 are effective for plan years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980E–1 Requirement of return and time for filing of the excise tax under section 4980E.

Q–1: If a person is liable for the excise tax under section 4980E, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–1: (a) *In general. See* §§ 54.6011–2, 54.6151–1 and 54.6071–1(c).

(b) *Effective/applicability date.* The rules in this Q & A–1 are effective for plan years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980F–1 Notice requirements for certain pension plan amendments significantly reducing the rate of future benefit accrual.

The following questions and answers concern the notification requirements imposed by 4980F of the Internal Revenue Code and section 204(h) of ERISA relating to a plan amendment of an applicable pension plan that significantly reduces the rate of future benefit accrual or that eliminates or significantly reduces an early retirement benefit or retirement-type subsidy.

LIST OF QUESTIONS

Q–1. What are the notice requirements of section 4980F(e) of the Internal Revenue Code and section 204(h) of ERISA?
Q–2. What are the differences between section 4980F and section 204(h)?
Q–3. What is an ''applicable pension plan'' to which section 4980F and section 204(h) apply?
Q–4. What is ''section 204(h) notice'' and what is a ''section 204(h) amendment''?
Q–5. For which amendments is section 204(h) notice required?
Q–6. What is an amendment that reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy for purposes of determining whether section 204(h) notice is required?

Q–7. What plan provisions are taken into account in determining whether an amendment is a section 204(h) amendment?
Q–8. What is the basic principle used in determining whether a reduction in the rate of future benefit accrual or a reduction in an early retirement benefit or retirement-type subsidy is significant for purposes of section 4980F and section 204(h)?
Q–9. When must section 204(h) notice be provided?
Q–10. To whom must section 204(h) notice be provided?
Q–11. What information is required to be provided in a section 204(h) notice?
Q–12. What special rules apply if participants can choose between the old and new benefit formulas?
Q–13. How may section 204(h) notice be provided?
Q–14. What are the consequences if a plan administrator fails to provide section 204(h) notice?
Q–15. What are some of the rules that apply with respect to the excise tax under section 4980F?
Q–16. How do section 4980F and section 204(h) apply when a business is sold?
Q–17. How are amendments to cease accruals and terminate a plan treated under section 4980F and section 204(h)?
Q–18. What are the effective dates of section 4980F, section 204(h), as amended by EGTRRA, and these regulations?

QUESTIONS AND ANSWERS

Q–1. What are the notice requirements of section 4980F(e) of the Internal Revenue Code and section 204(h) of ERISA?

A–1. (a) *Requirements of Internal Revenue Code section 4980F(e) and ERISA section 204(h).* Section 4980F of the Internal Revenue Code (section 4980F) and section 204(h) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1054(h) (section 204(h)) each generally requires notice of an amendment to an applicable pension plan that either provides for a significant reduction in the rate of future benefit accrual or that eliminates or significantly reduces an early retirement benefit or retirement-type subsidy. The notice is required to be provided to plan participants and alternate payees who are applicable individuals (as defined in Q&A–10 of this section), to certain employee organizations, and to contributing employers under a multiemployer plan (as described in Q&A–10(a) of this section). The plan administrator must generally provide the notice before the effective date of the plan amendment. Q&A–9 of this section sets forth the time frames for providing notice, Q&A–11 of this section sets forth the content requirements for the notice, and Q&A–12 of this section contains special rules for cases in which participants can choose between the old and new benefit formulas.

(b) *Other notice requirements.* Other provisions of law may require that certain parties be notified of a plan amendment. See, for example, sections 102 and 104 of ERISA, and the regulations thereunder, for requirements relating to summary plan descriptions and summaries of material modifications.

Q–2. What are the differences between section 4980F and section 204(h)?

A–2. The notice requirements of section 4980F generally are parallel to the notice requirements of section 204(h), as amended by the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107–16 (115 Stat. 38) (2001) (EGTRRA). However, the consequences of the failure to satisfy the requirements of the two provisions differ: Section 4980F imposes an excise tax on a failure to satisfy the notice requirements, while section 204(h)(6), as amended by EGTRRA, contains a special rule with respect to an egregious failure to satisfy the notice requirements. See Q&A–14 and Q&A–15 of this section. Except to the extent specifically indicated, these regulations apply both to section 4980F and to section 204(h).

Q–3. What is an ''applicable pension plan'' to which section 4980F and section 204(h) apply?

A–3. (a) *In general.* Section 4980F and section 204(h) apply to an applicable pension plan. For purposes of section 4980F, an *applicable pension plan* means a defined benefit plan qualifying under section 401(a) or 403(a) of the Internal Revenue Code, or an individual account plan that is subject to the funding standards of section 412 of the Internal Revenue Code. For purposes of section 204(h), an *applicable pension plan* means a defined benefit plan that is subject to part 2 of subtitle B of title I of ERISA, or an individual account plan that is

subject to such part 2 and to the funding standards of section 412 of the Internal Revenue Code. Accordingly, individual account plans that are not subject to the funding standards of section 412 of the Internal Revenue Code, such as profit-sharing and stock bonus plans and contracts under section 403(b) of the Internal Revenue Code, are not applicable pension plans to which section 4980F or section 204(h) apply. Similarly, a defined benefit plan that neither qualifies under section 401(a) or 403(a) of the Internal Revenue Code nor is subject to part 2 of subtitle B of title I of ERISA is not an applicable pension plan. Further, neither a governmental plan (within the meaning of section 414(d) of the Internal Revenue Code), nor a church plan (within the meaning of section 414(e) of the Internal Revenue Code) with respect to which no election has been made under section 410(d) of the Internal Revenue Code is an applicable pension plan.

(b) *Section 204(h) notice not required for small plans covering no employees.* Section 204(h) notice is not required for a plan under which no employees are participants covered under the plan, as described in § 2510.3–3(b) of the Department of Labor regulations, and which has fewer than 100 participants.

Q–4. What is ''section 204(h) notice'' and what is a ''section 204(h) amendment''?

A–4. (a) *Section 204(h) notice* is notice that complies with section 4980F(e) of the Internal Revenue Code, section 204(h)(1) of ERISA, and this section.

(b) A *section 204(h) amendment* is an amendment for which section 204(h) notice is required under this section.

Q–5. For which amendments is section 204(h) notice required?

A–5. (a) *Significant reduction in the rate of future benefit accrual.* Section 204(h) notice is required for an amendment to an applicable pension plan that provides for a significant reduction in the rate of future benefit accrual.

(b) *Early retirement benefits and retirement-type subsidies.* Section 204(h) notice is also required for an amendment to an applicable pension plan that provides for the significant reduction of an early retirement benefit or retirement-type subsidy. For purposes of this section, *early retirement benefit* and *retirement-type subsidy* mean early retirement benefits and retirement-type subsidies within the meaning of section 411(d)(6)(B)(i).

(c) *Elimination or cessation of benefits.* For purposes of this section, the terms *reduce* or *reduction* include eliminate or cease or elimination or cessation.

(d) *Delegation of authority to Commissioner.* The Commissioner may provide in revenue rulings, notices, or other guidance published in the Internal Revenue Bulletin (*see* § 601.601(d)(2) of this chapter) that section 204(h) notice need not be provided for plan amendments otherwise described in paragraph (a) or (b) of this Q&A–5 that the Commissioner determines to be necessary or appropriate, as a result of changes in the law, to maintain compliance with the requirements of the Internal Revenue Code (including requirements for tax qualification), ERISA, or other applicable federal law.

Q–6. What is an amendment that reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy for purposes of determining whether section 204(h) notice is required?

A–6. (a) *In general.* For purposes of determining whether section 204(h) notice is required, an amendment reduces the rate of future benefit accrual or reduces an early retirement benefit or retirement-type subsidy only as provided in paragraph (b) or (c) of this Q&A–6.

(b) *Reduction in rate of future benefit accrual*—(1) *Defined benefit plans.* For purposes of section 4980F and section 204(h), an amendment to a defined benefit plan reduces the rate of future benefit accrual only if it is reasonably expected that the amendment will reduce the amount of the future annual benefit commencing at normal retirement age (or at actual retirement age, if later) for benefits accruing for a year. For this purpose, the annual benefit commencing at normal retirement age is the benefit payable in the form in which the terms of the plan express the accrued benefit (or, in the case of a plan in which the accrued benefit is not expressed in the form of an annual benefit commencing at normal retirement age, the benefit payable in the form of a single life annuity commencing at

normal retirement age that is the actuarial equivalent of the accrued benefit expressed under the terms of the plan, as determined in accordance with section 411(c)(3) of the Internal Revenue Code).

(2) *Individual account plans.* For purposes of section 4980F and section 204(h), an amendment to an individual account plan reduces the rate of future benefit accrual only if it is reasonably expected that the amendment will reduce the amount of contributions or forfeitures allocated for any future year. Changes in the investments or investment options under an individual account plan are not taken into account for this purpose.

(3) *Determination of rate of future benefit accrual.* The rate of future benefit accrual for purposes of this paragraph (b) is determined without regard to optional forms of benefit within the meaning of §1.411(d)–4, Q&A–1(b) of this chapter (other than the annual benefit described in paragraph (b)(1) of this Q&A–6). The rate of future benefit accrual is also determined without regard to ancillary benefits and other rights or features as defined in §1.401(a)(4)–4(e) of this chapter.

(c) *Reduction of early retirement benefits or retirement-type subsidies.* For purposes of section 4980F and section 204(h), an amendment reduces an early retirement benefit or retirement-type subsidy only if it is reasonably expected that the amendment will eliminate or reduce an early retirement benefit or retirement-type subsidy.

Q–7. What plan provisions are taken into account in determining whether an amendment is a section 204(h) amendment?

A–7. (a) *Plan provisions taken into account*—(1) *In general.* All plan provisions that may affect the rate of future benefit accrual, early retirement benefits, or retirement-type subsidies of participants or alternate payees must be taken into account in determining whether an amendment is a section 204(h) amendment. For example, plan provisions that may affect the rate of future benefit accrual include the dollar amount or percentage of compensation on which benefit accruals are based; the definition of service or compensation taken into account in determining an employee's benefit accrual; the method of determining average compensation for calculating benefit accruals; the definition of normal retirement age in a defined benefit plan; the exclusion of current participants from future participation; benefit offset provisions; minimum benefit provisions; the formula for determining the amount of contributions and forfeitures allocated to participants' accounts in an individual account plan; in the case of a plan using permitted disparity under section 401(l) of the Internal Revenue Code, the amount of disparity between the excess benefit percentage or excess contribution percentage and the base benefit percentage or base contribution percentage (all as defined in section 401(l) of the Internal Revenue Code); and the actuarial assumptions used to determine contributions under a target benefit plan (as defined in §1.401(a)(4)–8(b)(3)(i) of this chapter). Plan provisions that may affect early retirement benefits or retirement-type subsidies include the right to receive payment of benefits after severance from employment and before normal retirement age and actuarial factors used in determining optional forms for distribution of retirement benefits.

(2) *Provisions incorporated by reference in plan.* If all or a part of a plan's rate of future benefit accrual, or an early retirement benefit or retirement-type subsidy provided under the plan, depends on provisions in another document that are referenced in the plan document, a change in the provisions of the other document is an amendment of the plan.

(b) *Plan provisions not taken into account*—(1) *In general.* Plan provisions that do not affect the rate of future benefit accrual of participants or alternate payees are not taken into account in determining whether there has been a reduction in the rate of future benefit accrual.

(2) *Interaction with section 411(d)(6).* Any benefit that is not a section 411(d)(6) protected benefit as described in §§1.411(d)–3(g)(14) and 1.411(d)–4, Q&A–1(d) of this chapter, or that is a section 411(d)(6) protected benefit that may be eliminated or reduced as permitted under §1.411(d)–3(c), (d), or (f),

or under § 1.411(d)–4, Q&A–2(a)(2), (a)(3), (b)(1), or (b)(2)(ii) through (b)(2)(xi) of this chapter, is not taken into account in determining whether an amendment is a section 204(h) amendment. Thus, for example, provisions relating to the right to make after-tax deferrals are not taken into account.

(c) *Examples*. The following examples illustrate the rules in this Q&A–7:

Example 1. (i) *Facts*. A defined benefit plan provides a normal retirement benefit equal to 50% of highest 5-year average pay multiplied by a fraction (not in excess of one), the numerator of which equals the number of years of participation in the plan and the denominator of which is 20. A plan amendment is adopted that changes the numerator or denominator of that fraction.

(ii) *Conclusion*. The plan amendment must be taken into account in determining whether there has been a reduction in the rate of future benefit accrual.

Example 2. (i) *Facts*. Plan C is a multiemployer defined benefit plan subject to several collective bargaining agreements. The specific benefit formula under Plan C that applies to an employee depends on the hourly rate of contribution of the employee's employer, which is set forth in the provisions of the collective bargaining agreements that are referenced in the Plan C document. Collective Bargaining Agreement A between Employer B and the union representing employees of Employer B is renegotiated to provide that the hourly contribution rate for an employee of B who is subject to the Collective Bargaining Agreement A will decrease. That decrease will result in a decrease in the rate of future benefit accrual for employees of B.

(ii) *Conclusion*. Under paragraph (a)(2) of this Q&A–7, the change to Collective Bargaining Agreement A is a plan amendment that is a section 204(h) amendment if the reduction in the rate of future benefit accrual is significant.

Q–8. What is the basic principle used in determining whether a reduction in the rate of future benefit accrual or a reduction in an early retirement benefit or retirement-type subsidy is significant for purposes of section 4980F and section 204(h)?

A–8. (a) *General rule*. Whether an amendment reducing the rate of future benefit accrual or eliminating or reducing an early retirement benefit or retirement-type subsidy provides for a reduction that is significant for purposes of section 4980F (and section 204(h) of ERISA) is determined based on reasonable expectations taking into account the relevant facts and circumstances at the time the amendment is adopted, or, if earlier, at the effective date of the amendment.

(b) *Application for determining significant reduction in the rate of future benefit accrual*. For a defined benefit plan, the determination of whether an amendment provides for a significant reduction in the rate of future benefit accrual is made by comparing the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later), as determined under Q&A–6(b)(1) of this section, under the terms of the plan as amended with the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later), as determined under Q&A–6(b)(1) of this section, under the terms of the plan prior to amendment. For an individual account plan, the determination of whether an amendment provides for a significant reduction in the rate of future benefit accrual is made in accordance with Q&A–6(b)(2) of this section by comparing the amounts to be allocated in the future to participants' accounts under the terms of the plan as amended with the amounts to be allocated in the future to participants' accounts under the terms of the plan prior to amendment. An amendment to convert a money purchase pension plan to a profit-sharing or other individual account plan that is not subject to section 412 of the Internal Revenue Code is, in all cases, deemed to be an amendment that provides for a significant reduction in the rate of future benefit accrual.

(c) *Application to certain amendments reducing early retirement benefits or retirement-type subsidies*. Section 204(h) notice is not required for an amendment that reduces an early retirement benefit or retirement-type subsidy if the amendment is permitted under the third sentence of section 411(d)(6)(B) of the Internal Revenue Code and paragraphs (c), (d), and (f) of § 1.411(d)–3 of this chapter (relating to the elimination or reduction of benefits or subsidies which create significant burdens or complexities for the plan and plan

participants unless the amendment adversely affects the rights of any participant in a more than *de minimis* manner). However, in determining whether an amendment reducing a retirement-type subsidy constitutes a significant reduction because it reduces a retirement-type subsidy as permitted under §1.411(d)–3(e)(6) of this chapter, the amendment is treated in the same manner as an amendment that limits the retirement-type subsidy to benefits that accrue before the applicable amendment date (as defined at §1.411(d)–3(g)(4) of this chapter) with respect to each participant or alternate payee to whom the reduction is reasonably expected to apply.

(d) *Plan amendments reflecting a change in statutorily mandated minimum present value rules.* If a defined benefit plan offers a distribution to which the minimum present value rules of section 417(e)(3) apply (other than a payment to which section 411(a)(13)(A) applies) and the plan is amended to reflect the changes to the applicable interest rate and applicable mortality table in section 417(e)(3) made by the Pension Protection Act of 2006, Public Law 109–780 (120 Stat. 780) (PPA '06) (and no change is made in the dates on which the payment will be made), no section 204(h) notice is required to be provided.

(e) *Examples.* The following examples illustrate the rules in this Q&A–8:

Example 1. (i) *Facts.* Pension Plan A is a defined benefit plan that provides a rate of benefit accrual of 1% of highest-5 years pay multiplied by years of service, payable annually for life commencing at normal retirement age (or at actual retirement age, if later). An amendment to Plan A is adopted on August 1, 2009, effective January 1, 2010, to provide that any participant who separates from service after December 31, 2009, and before January 1, 2015, will have the same number of years of service he or she would have had if his or her service continued to December 31, 2014.

(ii) *Conclusion.* In this example, the effective date of the plan amendment is January 1, 2010. While the amendment will result in a reduction in the annual rate of future benefit accrual from 2011 through 2014 (because, under the amendment, benefits based upon an additional 5 years of service accrue on January 1, 2010, and no additional service is credited after January 1, 2010 until January 1, 2015), the amendment does not result in a reduction that is significant because the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later) under the terms of the plan as amended is not under any conditions less than the amount of the annual benefit commencing at normal retirement age (or at actual retirement age, if later) to which any participant would have been entitled under the terms of the plan had the amendment not been made.

Example 2. (i) *Facts.* The facts are the same as in *Example 1,* except that the 2009 amendment does not alter the plan provisions relating to a participant's number of years of service, but instead amends the plan's provisions relating to early retirement benefits. Before the amendment, the plan provides for distributions before normal retirement age to be actuarially reduced, but, if a participant retires after attainment of age 55 and completion of 10 years of service, the applicable early retirement reduction factor is 3% per year for the years between the ages 65 and 62 and 6% per year for the ages from 62 to 55. The amendment changes these provisions so that an actuarial reduction applies in all cases, but, in accordance with section 411(d)(6)(B), provides that no participant's early retirement benefit will be less than the amount provided under the plan as in effect on December 31, 2009 with respect to service before January 1, 2010. For participant X, the reduction is significant.

(ii) *Conclusion.* The amendment will result in a reduction in a retirement-type subsidy provided under Plan A (*i.e.*, Plan A's early retirement subsidy). Section 204(h) notice must be provided to participant X and any other participant for whom the reduction is significant and the notice must be provided at least 45 days before January 1, 2010 (or by such other date as may apply under Q&A–9 of this section).

Example 3. (i) *Facts.* The facts are the same as in *Example 2,* except that, for participant X, the change does not go into effect for any annuity commencement date before January 1, 2011. Participant X continues employment through January 1, 2011.

(ii) *Conclusion.* The conclusion is the same as in *Example 2.* Taking into account the rule in the second sentence of Q&A–8(c) of this section, the reduction that occurs for participant X on January 1, 2011, is treated as the same reduction that occurs under *Example 2.* Accordingly, assuming that the reduction is significant, section 204(h) notice must be provided to participant X at least 45 days before the January 1, 2010 effective date of the amendment (or by such other date as may apply under Q&A–9 of this section).

Q–9. When must section 204(h) notice be provided?

A–9. (a) *45-day general rule*. Except as otherwise provided in this Q&A–9, section 204(h) notice must be provided at least 45 days before the effective date of any section 204(h) amendment. See paragraph (e) of this Q&A–9 for special rules for amendments permitting participant choice.

(b) *15-day rule for small plans*. Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, section 204(h) notice must be provided at least 15 days before the effective date of any section 204(h) amendment in the case of a small plan. For purposes of this section, a small plan is a plan that the plan administrator reasonably expects to have, on the effective date of the section 204(h) amendment, fewer than 100 participants who have an accrued benefit under the plan.

(c) *15-day rule for multiemployer plans*. Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, section 204(h) notice must be provided at least 15 days before the effective date of any section 204(h) amendment in the case of a multiemployer plan. For purposes of this section, a multiemployer plan means a multiemployer plan as defined in section 414(f) of the Internal Revenue Code.

(d) *Special timing rule for business transactions*—(1) *15-day rule for section 204(h) amendment in connection with an acquisition or disposition*. Except for amendments described in paragraphs (d)(2) and (g) of this Q&A–9, if a section 204(h) amendment is adopted in connection with an acquisition or disposition, section 204(h) notice must be provided at least 15 days before the effective date of the section 204(h) amendment.

(2) *Later notice permitted for a section 204(h) amendment significantly reducing early retirement benefit or retirement-type subsidies in connection with certain plan transfers, mergers, or consolidations*. If a section 204(h) amendment is adopted with respect to liabilities that are transferred to another plan in connection with a transfer, merger, or consolidation of assets or liabilities as described in section 414(l) of the Internal Revenue Code and § 1.414(l)–1 of this chapter, the amendment is adopted in connection with an acquisition or disposition, and the amendment significantly reduces an early retirement benefit or retirement-type subsidy, but does not significantly reduce the rate of future benefit accrual, then section 204(h) notice must be provided no later than 30 days after the effective date of the section 204(h) amendment.

(3) *Definition of acquisition or disposition*. For purposes of this paragraph (d), see § 1.410(b)–2(f) of this chapter for the definition of acquisition or disposition.

(e) *Timing rule for amendments permitting participant choice*. In general, section 204(h) notice of a section 204(h) amendment that provides applicable individuals with a choice between the old and the new benefit formulas (as described in Q&A–12 of this section) must be provided in accordance with the time period applicable under paragraphs (a) through (d) of this Q&A–9. See Q&A–12 of this section for additional guidance regarding section 204(h) notice in connection with participant choice.

(f) *Special timing rule for certain plans maintained by commercial airlines*. *See* section 402 of PPA '06 for a special rule that applies to certain plans maintained by an employer that is a commercial passenger airline or the principal business of which is providing catering services to a commercial passenger airline. Under this special rule, section 204(h) notice must be provided at least 15 days before the effective date of the amendment.

(g) *Special timing rules relating to certain section 204(h) amendments that reduce section 411(d)(6) protected benefits*—(1) *Plan amendments permitted to reduce prior accruals*. This paragraph (g) generally provides special rules with respect to a plan amendment that would not violate section 411(d)(6) even if the amendment were to reduce section 411(d)(6) protected benefits, which are limited to accrued benefits that are attributable to service before the applicable amendment date. For example, this paragraph (g) applies to amendments that are permitted to be effective retroactively under section 412(d)(2) of the Code (section 412(c)(8) for plan years beginning before January 1, 2008), section 418D of the Code, section 418E of the Code, section 4281 of ERISA, or section 1107 of PPA '06. *See*, generally, § 1.411(d)–3(a)(1).

(2) *General timing rule for amendments to which this paragraph (g) applies.* For an amendment to which this paragraph (g) applies, the amendment is effective on the first date on which the plan is operated as if the amendment were in effect. Thus, except as otherwise provided in this paragraph (g), a section 204(h) notice for an amendment to which paragraph (a) of this section applies that is adopted after the effective date of the amendment must be provided, with respect to any applicable individual, at least 45 days before (or such other date as may apply under paragraph (b), (c), (d), or (f) of this Q&A–9) the date the amendment is put into operational effect.

(3) *Special rules for section 204(h) notices provided in connection with other disclosure requirements*—(i) *In general.* Notwithstanding the requirements in this Q&A–9 and Q&A–11 of this section, if a plan provides one of the notices in paragraph (g)(3)(ii) of this Q&A–9, in accordance with the applicable timing and content rules for such notice, the plan is treated as timely providing a section 204(h) notice with respect to a section 204(h) amendment.

(ii) *Notice requirements.* The notices in this paragraph (g)(3)(ii) are—

(A) A notice required under any revenue ruling, notice, or other guidance published under the authority of the Commissioner in the Internal Revenue Bulletin to affected parties in connection with a retroactive plan amendment described in section 412(d)(2) (section 412(c)(8) for plan years beginning before January 1, 2008);

(B) A notice required under section 101(j) of ERISA if an amendment is adopted to comply with the benefit limitation requirements of section 206(g) of ERISA (section 436 of the Code);

(C) A notice required under section 432(b)(3)(D) of the Code for an amendment adopted to comply with the benefit restrictions under section 432(f)(2);

(D) A notice required under section 418D, or section 4244A(b) of ERISA, for an amendment that reduces or eliminates accrued benefits attributable to employer contributions with respect to a multiemployer plan in reorganization;

(E) A notice required under section 418E, or section 4245(e) of ERISA, relating to the effects of the insolvency status for a multiemployer plan; and

(F) A notice required under section 4281 of ERISA for an amendment of a multiemployer plan reducing benefits pursuant to section 4281(c) of ERISA.

(4) *Delegation of authority to Commissioner.* The Commissioner may provide special rules under section 4980F, in revenue rulings, notices, or other guidance published in the Internal Revenue Bulletin (*see* § 601.601(d)(2)(ii)(*b*) of this chapter), that the Commissioner determines to be necessary or appropriate with respect to a section 204(h) amendment—

(A) That applies to benefits accrued before the applicable amendment date but that does not violate section 411(d)(6); or

(B) For which there is a required notice relating to a reduction in benefits and such notice has timing and content requirements similar to a section 204(h) notice with respect to a significant reduction in the rate of future benefit accruals.

Q–10. To whom must section 204(h) notice be provided?

A–10. (a) *In general.* Section 204(h) notice must be provided to each applicable individual, to each employee organization representing participants who are applicable individuals, and, for plan years beginning after December 31, 2007, to each employer that has an obligation to contribute (within the meaning of section 4212(a) of ERISA) to a multiemployer plan. A special rule is provided in paragraph (d) of this Q&A–10.

(b) *Applicable individual.* Applicable individual means each participant in the plan, and any alternate payee, whose rate of future benefit accrual under the plan is reasonably expected to be significantly reduced, or for whom an early retirement benefit or retirement-type subsidy under the plan may reasonably be expected to be significantly reduced, by the section 204(h) amendment. The determination is made with respect to individuals who are reasonably expected to be participants or alternate payees in the plan at the effective date of the section 204(h) amendment.

(c) *Alternate payee.* Alternate payee means a beneficiary who is an alternate payee (within the meaning of section 414(p)(8) of the Internal Revenue Code) under an applicable qualified domestic relations order (within the meaning of section 414(p)(1)(A) of the Internal Revenue Code).

(d) *Designees.* Section 204(h) notice may be provided to a person designated in writing by an applicable individual or by an employee organization representing participants who are applicable individuals, instead of being provided to that applicable individual or employee organization. Any designation of a representative made through an electronic method that satisfies standards similar to those of Q&A–13(c)(1) of this section satisfies the requirement that a designation be in writing.

(e) *Facts and circumstances test.* Whether a participant or alternate payee is an applicable individual is determined on a typical business day that is reasonably proximate to the time the section 204(h) notice is provided (or at the latest date for providing section 204(h) notice, if earlier), based on all relevant facts and circumstances.

(f) *Examples.* The following examples illustrate the rules in this Q&A–10:

Example 1. (i) *Facts.* A defined benefit plan requires an individual to complete 1 year of service to become a participant who can accrue benefits, and participants cease to accrue benefits under the plan at severance from employment with the employer. There are no alternate payees and employees are not represented by an employee organization. On November 18, 2004, the plan is amended effective as of January 1, 2005 to reduce significantly the rate of future benefit accrual. Section 204(h) notice is provided on November 1, 2004.

(ii) *Conclusion.* Section 204(h) notice is only required to be provided to individuals who, based on the facts and circumstances on November 1, 2004, are reasonably expected to have completed at least 1 year of service and to be employed by the employer on January 1, 2005.

Example 2. (i) *Facts.* The facts are the same as in *Example 1,* except that the sole effect of the plan amendment is to alter the pre-amendment plan provisions under which benefits payable to an employee who retires after 20 or more years of service are unreduced for commencement before normal retirement age. The amendment requires 30 or more years of service in order for benefits commencing before normal retirement age to be unreduced, but the amendment only applies for future benefit accruals.

(ii) *Conclusion.* Section 204(h) notice is only required to be provided to individuals who, on January 1, 2005, have completed at least 1 year of service but less than 30 years of service, are employed by the employer, have not attained normal retirement age, and will have completed 20 or more years of service before normal retirement age if their employment continues to normal retirement age.

Example 3. (i) *Facts.* A plan is amended to reduce significantly the rate of future benefit accrual for all current employees who are participants. Based on the facts and circumstances, it is reasonable to expect that the amendment will not reduce the rate of future benefit accrual of former employees who are currently receiving benefits or of former employees who are entitled to deferred vested benefits.

(ii) *Conclusion.* The plan administrator is not required to provide section 204(h) notice to any former employees.

Example 4. (i) *Facts.* The facts are the same as in *Example 3,* except that the plan covers two groups of alternate payees. The alternate payees in the first group are entitled to a certain percentage or portion of the former spouse's accrued benefit and, for this purpose, the accrued benefit is determined at the time the former spouse begins receiving retirement benefits under the plan. The alternate payees in the second group are entitled to a certain percentage or portion of the former spouse's accrued benefit and, for this purpose, the accrued benefit was determined at the time the qualified domestic relations order was issued by the court.

(ii) *Conclusion.* It is reasonable to expect that the benefits to be received by the second group of alternate payees will not be affected by any reduction in a former spouse's rate of future benefit accrual. Accordingly, the plan administrator is not required to provide section 204(h) notice to the alternate payees in the second group.

Example 5. (i) *Facts.* A plan covers hourly employees and salaried employees. The plan provides the same rate of benefit accrual for both groups. The employer amends the plan to reduce significantly the rate of future benefit accrual of the salaried employees only. At that time, it is reasonable to expect that only a small percentage of hourly employees will become salaried in the future.

(ii) *Conclusion.* The plan administrator is not required to provide section 204(h) notice to the participants who are currently hourly employees.

Example 6. (i) *Facts.* A plan covers employees in Division M and employees in Division N. The plan provides the same rate of benefit accrual for both groups. The employer

amends the plan to reduce significantly the rate of future benefit accrual of employees in Division M. At that time, it is reasonable to expect that in the future only a small percentage of employees in Division N will be transferred to Division M.

(ii) *Conclusion*. The plan administrator is not required to provide section 204(h) notice to the participants who are employees in Division N.

Example 7. (i) *Facts*. The facts are the same facts as in *Example 6*, except that at the time the amendment is adopted, it is expected that thereafter Division N will be merged into Division M in connection with a corporate reorganization (and the employees in Division N will become subject to the plan's amended benefit formula applicable to the employees in Division M).

(ii) *Conclusion*. In this case, the plan administrator must provide section 204(h) notice to the participants who are employees in Division M and to the participants who are employees in Division N.

Example 8. (i) *Facts*. A plan is amended to reduce significantly the rate of future benefit accrual for all current employees who are participants. The plan amendment will be effective on January 1, 2004. The plan will provide the notice to applicable individuals on October 31, 2003. In determining which current employees are applicable individuals, the plan administrator determines that October 1, 2003, is a typical business day that is reasonably proximate to the time the section 204(h) notice is provided.

(ii) *Conclusion*. In this case, October 1, 2003 is a typical business day that satisfies the requirements of Q&A–10(e) of this section.

Q–11. What information is required to be provided in a section 204(h) notice?

A–11. (a) *Explanation of notice requirements*—(1) *In general*. Section 204(h) notice must include sufficient information to allow applicable individuals to understand the effect of the plan amendment. In order to satisfy this rule, a plan administrator providing section 204(h) notice must generally satisfy paragraphs (a)(2), (a)(3), (a)(4), (a)(5), and (a)(6) of this Q&A–11. See paragraph (g)(3) of Q&A–9 of this section for special rules relating to section 204(h) notices provided in connection with certain other written notices. *See* also paragraph (g)(4) of Q&A–9 of this section for a delegation of authority to the Commissioner to provide special rules.

(2) *Information in section 204(h) notice*. The information in a section 204(h) notice must be written in a manner calculated to be understood by the average plan participant and to apprise the applicable individual of the significance of the notice.

(3) *Required narrative description of amendment*—(i) *Reduction in rate of future benefit accrual*. In the case of an amendment reducing the rate of future benefit accrual, the notice must include a description of the benefit or allocation formula prior to the amendment, a description of the benefit or allocation formula under the plan as amended, and the effective date of the amendment.

(ii) *Reduction in early retirement benefit or retirement-type subsidy*. In the case of an amendment that reduces an early retirement benefit or retirement-type subsidy (other than as a result of an amendment reducing the rate of future benefit accrual), the notice must describe how the early retirement benefit or retirement-type subsidy is calculated from the accrued benefit before the amendment, how the early retirement benefit or retirement-type subsidy is calculated from the accrued benefit after the amendment, and the effective date of the amendment. For example, if, for a plan with a normal retirement age of 65, the change is from an unreduced normal retirement benefit at age 55 to an unreduced normal retirement benefit at age 60 for benefits accrued in the future, with an actuarial reduction to apply for benefits accrued in the future to the extent that the early retirement benefit begins before age 60, the notice must state the change and specify the factors that apply in calculating the actuarial reduction (for example, a 5% per year reduction applies for early retirement before age 60).

(4) *Sufficient information to determine the approximate magnitude of reduction*—(i) *General rule*. (A) Section 204(h) notice must include sufficient information for each applicable individual to determine the approximate magnitude of the expected reduction for that individual. Thus, in any case in which it is not reasonable to expect that the approximate magnitude of the reduction for each applicable individual will be reasonably apparent from the description of the amendment provided in accordance with paragraph (a)(3) of this

Q&A–11, further information is required. The further information may be provided by furnishing additional narrative information or in other information that satisfies this paragraph of this section.

(B) To the extent any expected reduction is not uniformly applicable to all participants, the notice must either identify the general classes of participants to whom the reduction is expected to apply, or by some other method include sufficient information to allow each applicable individual receiving the notice to determine which reductions are expected to apply to that individual.

(ii) *Illustrative examples*—(A) *Requirement generally*. The requirement to include sufficient information for each applicable individual to determine the approximate magnitude of the expected reduction for that individual under (a)(4)(i)(A) of this Q&A–11 is deemed satisfied if the notice includes one or more illustrative examples showing the approximate magnitude of the reduction in the examples, as provided in this paragraph (a)(4)(ii). Illustrative examples are in any event required to be provided for any change from a traditional defined benefit formula to a cash balance formula or a change that results in a period of time during which there are no accruals (or minimal accruals) with regard to normal retirement benefits or an early retirement subsidy (a wear-away period).

(B) *Examples must bound the range of reductions*. Where an amendment results in reductions that vary (either among participants, as would occur for an amendment converting a traditional defined benefit formula to a cash balance formula, or over time as to any individual participant, as would occur for an amendment that results in a wear-away period), the illustrative example(s) provided in accordance with this paragraph (a)(4)(ii) must show the approximate range of the reductions. However, any reductions that are likely to occur in only a de minimis number of cases are not required to be taken into account in determining the range of the reductions if a narrative statement is included to that effect and examples are provided that show the approximate range of the reductions in other cases. Amendments for which the maximum reduction occurs under identifiable circumstances, with proportionately smaller reductions in other cases, may be illustrated by one example illustrating the maximum reduction, with a statement that smaller reductions also occur. Further, assuming that the reduction varies from small to large depending on service or other factors, two illustrative examples may be provided showing the smallest likely reduction and the largest likely reduction.

(C) *Assumptions used in examples*. The examples provided under this paragraph (a)(4)(ii) are not required to be based on any particular form of payment (such as a life annuity or a single sum), but may be based on whatever form appropriately illustrates the reduction. The examples generally may be based on any reasonable assumptions (for example, assumptions relating to the representative participant's age, years of service, and compensation, along with any interest rate and mortality table used in the illustrations, as well as salary scale assumptions used in the illustrations for amendments that alter the compensation taken into account under the plan), but the section 204(h) notice must identify those assumptions. However, if a plan's benefit provisions include a factor that varies over time (such as a variable interest rate), the determination of whether an amendment is reasonably expected to result in a wear-away period must be based on the value of the factor applicable under the plan at a time that is reasonably close to the date section 204(h) notice is provided, and any wear-away period that is solely a result of a future change in the variable factor may be disregarded. For example, to determine whether a wear-away occurs as a result of a section 204(h) amendment that converts a defined benefit plan to a cash balance pension plan that will credit interest based on a variable interest factor specified in the plan, the future interest credits must be projected based on the interest rate applicable under the variable factor at the time section 204(h) notice is provided.

(D) *Individual statements.* This paragraph (a)(4)(ii) may be satisfied by providing a statement to each applicable individual projecting what that individual's future benefits are reasonably expected to be at various future dates and what that individual's future benefits would have been under the terms of the plan as in effect before the section 204(h) amendment, provided that the statement includes the same information required for examples under paragraphs (a)(4)(ii)(A) through (C) of this Q&A–11, including showing the approximate range of the reductions for the individual if the reductions vary over time and identification of the assumptions used in the projections.

(5) *No false or misleading information.* A section 204(h) notice may not include materially false or misleading information (or omit information so as to cause the information provided to be misleading).

(6) *Additional information when reduction not uniform*—(i) *In general.* If an amendment by its terms affects different classes of participants differently (e.g., one new benefit formula will apply to Division A and another to Division B), then the requirements of paragraph (a) of this Q&A–11 apply separately with respect to each such general class of participants. In addition, the notice must include sufficient information to enable an applicable individual who is a participant to understand which class he or she is a member of.

(ii) *Option for different section 204(h) notices.* If a section 204(h) amendment affects different classes of applicable individuals differently, the plan administrator may provide to differently affected classes of applicable individuals a section 204(h) notice appropriate to those individuals. Such section 204(h) notice may omit information that does not apply to the applicable individuals to whom it is furnished, but must identify the class or classes of applicable individuals to whom it is provided.

(b) *Examples.* The following examples illustrate the requirements paragraph (a) of this Q&A–11. In each example, it is assumed that the actual notice provided is written in a manner calculated to be understood by the average plan participant and to apprise the applicable individual of the significance of the notice in accordance with paragraph (a)(2) of this Q&A–11. The examples are as follows:

Example 1. (i) *Facts.* Plan A provides that a participant is entitled to a normal retirement benefit of 2% of the participant's average pay over the 3 consecutive years for which the average is the highest (highest average pay) multiplied by years of service. Plan A is amended to provide that, effective January 1, 2004, the normal retirement benefit will be 2% of the participant's highest average pay multiplied by years of service before the effective date, plus 1% of the participant's highest average pay multiplied by years of service after the effective date. The plan administrator provides notice that states: ''Under the Plan's current benefit formula, a participant's normal retirement benefit is 2% of the participant's average pay over the 3 consecutive years for which the average is the highest multiplied by the participant's years of service. This formula is being changed by a plan amendment. Under the Plan as amended, a participant's normal retirement benefit will be the sum of 2% of the participant's average pay over the 3 consecutive years for which the average is the highest multiplied by years of service before the January 1, 2004 effective date, plus 1% of the participant's average pay over the 3 consecutive years for which the average is the highest multiplied by the participant's years of service after December 31, 2003. This change is effective on January 1, 2004.'' The notice does not contain any additional information.

(ii) *Conclusion.* The notice satisfies the requirements of paragraph (a) of this Q&A–11.

Example 2. (i) *Facts.* Plan B provides that a participant is entitled to a normal retirement benefit at age 64 of 2.2% of the participant's career average pay multiplied by years of service. Plan B is amended to cease all accruals, effective January 1, 2004. The plan administrator provides notice that includes a description of the old benefit formula, a statement that, after December 31, 2003, no participant will earn any further accruals, and the effective date of the amendment. The notice does not contain any additional information.

(ii) *Conclusion.* The notice satisfies the requirements of paragraph (a) of this Q&A–11.

Example 3. (i) *Facts.* Plan C provides that a participant is entitled to a normal retirement benefit at age 65 of 2% of career average compensation multiplied by years of service. Plan C is amended to provide that the normal retirement benefit will be 1% of average pay over the 3 consecutive years for which the average is the highest multiplied by years of service. The amendment only applies to accruals for years of service after the amendment, so that each employee's accrued

benefit is equal to the sum of the benefit accrued as of the effective date of the amendment plus the accrued benefit equal to the new formula applied to years of service beginning on or after the effective date. The plan administrator provides notice that describes the old and new benefit formulas and also explains that for an individual whose compensation increases over the individual's career such that the individual's highest 3-year average exceeds the individual's career average, the reduction will be less or there may be no reduction. The notice does not contain any additional information.

(ii) *Conclusion*. The notice satisfies the requirements of paragraph (a) of this Q&A–11.

Example 4. (i) *Facts*. (A) Plan D is a defined benefit pension plan under which each participant accrues a normal retirement benefit, as a life annuity beginning at the normal retirement age of 65, equal to the participant's number of years of service multiplied by 1.5 percent multiplied by the participant's average pay over the 3 consecutive years for which the average is the highest. Plan D provides early retirement benefits for former employees beginning at or after age 55 in the form of an early retirement annuity that is actuarially equivalent to the normal retirement benefit, with the reduction for early commencement based on reasonable actuarial assumptions that are specified in Plan D. Plan D provides for the suspension of benefits of participants who continue in employment beyond normal retirement age, in accordance with section 203(a)(3)(B) of ERISA and regulations thereunder issued by the Department of Labor. The pension of a participant who retires after age 65 is calculated under the same normal retirement benefit formula, but is based on the participant's service credit and highest 3-year pay at the time of late retirement with any appropriate actuarial increases.

(B) Plan D is amended, effective July 1, 2005, to change the formula for all future accruals to a cash balance formula under which the opening account balance for each participant on July 1, 2005, is zero, hypothetical pay credits equal to 5 percent of pay are credited to the account thereafter, and hypothetical interest is credited monthly based on the applicable interest rate under section 417(e)(3) of the Internal Revenue Code at the beginning of the quarter. Any participant who terminates employment with vested benefits can receive an actuarially equivalent annuity (based on the same reasonable actuarial assumptions that are specified in Plan D) commencing at any time after termination of employment and before the plan's normal retirement age of 65. The benefit resulting from the hypothetical account balance is in addition to the benefit accrued before July 1, 2005 (taking into account only service and highest 3-year pay before July 1, 2005), so that it is reasonably expected that no wear-away period will result from the amendment. The plan administrator expects that, as a general rule, depending on future pay increases and future interest rates, the rate of future benefit accrual after the conversion is higher for participants who accrue benefits before approximately age 50 and after approximately age 70, but is lower for participants who accrue benefits between approximately age 50 and age 70.

(C) The plan administrator of Plan D announces the conversion to a cash balance formula on May 16, 2005. The announcement is delivered to all participants and includes a written notice that describes the old formula, the new formula, and the effective date.

(D) In addition, the notice states that the Plan D formula before the conversion provided a normal retirement benefit equal to the product of a participant's number of years of service multiplied by 1.5 percent multiplied by the participant's average pay over the 3 years for which the average is the highest (highest 3-year pay). The notice includes an example showing the normal retirement benefit that will be accrued after June 30, 2005 for a participant who is age 49 with 10 years of service at the time of the conversion. The plan administrator reasonably believes that such a participant is representative of the participants whose rate of future benefit accrual will be reduced as a result of the amendment. The example estimates that, if the participant continues employment to age 65, the participant's normal retirement benefit for service from age 49 to age 65 will be $657 per month for life. The example assumes that the participant's pay is $50,000 at age 49. The example states that the estimated $657 monthly pension accrues over the 16-year period from age 49 to age 65 and that, based on assumed future pay increases, this amount annually would be 9.1 percent of the participant's highest 3-year pay at age 65, which over the 16 years from age 49 to age 65 averages 0.57 percent per year multiplied by the participant's highest 3-year pay. The example also states that the sum of the monthly annuity accrued before the conversion in the 10-year period from age 39 to age 49 plus the $657 monthly annuity estimated to be accrued over the 16-year period from age 49 to age 65 is $1,235 and that, based on assumed future increases in pay, this would be 17.1 percent of the participant's highest 3-year pay at age 65, which over the employee's career from age 39 to age 65 averages 0.66 percent per year multiplied by the participant's highest 3-year pay. The notice also includes two other examples with similar information, one of which is intended to show the circumstances in which a small reduction may occur and the other of which shows the largest reduction that the plan administrator thinks is likely to occur. The notice states that the estimates are based on the

assumption that pay increases annually after June 30, 2005, at a 4 percent rate. The notice also specifies that the applicable interest rate under section 417(e) for hypothetical interest credits after June 30, 2005 is assumed to be 6 percent, which is the section 417(e) of the Internal Revenue Code applicable interest rate under the plan for 2005.

(ii) *Conclusion.* The information in the notice, as described in paragraph (i)(C) and (i)(D) of this *Example 4*, satisfies the requirements of paragraph (a)(3) of this Q&A–11 with respect to applicable individuals who are participants. The requirements of paragraph (a)(4) of this Q&A–11 are satisfied because, as noted in paragraph (i)(D) of this *Example 4*, the notice describes the old formula and describes the estimated future accruals under the new formula in terms that can be readily compared to the old formula, *i.e.*, the notice states that the estimated $657 monthly pension accrued over the 16-year period from age 49 to age 65 averages 0.57 percent of the participant's highest 3-year pay at age 65. The requirement in paragraph (a)(4)(ii) of this Q&A–11 that the examples include sufficient information to be able to determine the approximate magnitude of the reduction would also be satisfied if the notice instead directly stated the amount of the monthly pension that would have accrued over the 16-year period from age 49 to age 65 under the old formula.

Example 5. (i) *Facts.* The facts are the same as in *Example 4*, except that, under the plan as in effect before the amendment, the early retirement pension for a participant who terminates employment after age 55 with at least 20 years of service is equal to the normal retirement benefit without reduction from age 65 to age 62 and reduced by only 5 percent per year for each year before age 62. As a result, early retirement benefits for such a participant constitute a retirement-type subsidy. The plan as in effect after the amendment provides an early retirement benefit equal to the sum of the early retirement benefit payable under the plan as in effect before the amendment taking into account only service and highest 3-year pay before July 1, 2005, plus an early retirement annuity that is actuarially equivalent to the account balance for service after June 30, 2005. The notice provided by the plan administrator describes the old early retirement annuity, the new early retirement annuity, and the effective date. The notice includes an estimate of the early retirement annuity payable to the illustrated participant for service after the conversion if the participant were to retire at age 59 (which the plan administrator believes is a typical early retirement age) and elect to begin receiving an immediate early retirement annuity. The example states that the normal retirement benefit expected to be payable at age 65 as a result of service from age 49 to age 59 is $434 per month for life beginning at age 65 and that the early retirement annuity expected to be payable as a result of service from age 49 to age 59 is $270 per month for life beginning at age 59. The example states that the monthly early retirement annuity of $270 is 38 percent less than the monthly normal retirement benefit of $434, whereas a 15 percent reduction would have applied under the plan as in effect before the amendment. The notice also includes similar information for examples that show the smallest and largest reduction that the plan administrator thinks is likely to occur in the early retirement benefit. The notice also specifies the applicable interest rate, mortality table, and salary scale used in the example to calculate the early retirement reductions.

(ii) *Conclusion.* The information in the notice, as described in paragraphs (i)(C) and (D) of *Example 4* and paragraph (i) of this *Example 5*, satisfies the requirements of paragraph (a)(3) of this Q&A–11 with respect to applicable individuals who are participants. The requirements of paragraph (a)(4) of this Q&A–11 are satisfied because, as noted in paragraph (i) of this *Example 5*, the notice describes the early retirement subsidy under the old formula and describes the estimated early retirement pension under the new formula in terms that can be readily compared to the old formula, *i.e.*, the notice states that the monthly early retirement pension of $270 is 38 percent less than the monthly normal retirement benefit of $434, whereas a 15 percent reduction would have applied under the plan as in effect before the amendment. The requirements of paragraph (a)(4)(ii) of this Q&A–11 that the examples include sufficient information to be able to determine the approximate magnitude of the reduction would also be satisfied if the notice instead directly stated the amount of the monthly early retirement pension that would be payable at age 59 under the old formula.

Q–12. What special rules apply if participants can choose between the old and new benefit formulas?

A–12. In any case in which an applicable individual can choose between the benefit formula (including any early retirement benefit or retirement-type subsidy) in effect before the section 204(h) amendment (old formula) or the benefit formula in effect after the section 204(h) amendment (new formula), section 204(h) notice has not been provided unless the applicable individual has been provided the information required under Q&A–11 of this section, and has also been provided sufficient information to enable the individual to make an informed choice between the

old and new benefit formulas. The information required under Q&A–11 of this section must be provided by the date otherwise required under Q&A–9 of this section. The information sufficient to enable the individual to make an informed choice must be provided within a period that is reasonably contemporaneous with the date by which the individual is required to make his or her choice and that allows sufficient advance notice to enable the individual to understand and consider the additional information before making that choice.

Q–13. How may section 204(h) notice be provided?

A–13. (a) *Delivering section 204(h) notice.* A plan administrator (including a person acting on behalf of the plan administrator, such as the employer or plan trustee) must provide section 204(h) notice through a method that results in actual receipt of the notice or the plan administrator must take appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice. Section 204(h) notice must be provided either in the form of a paper document or in an electronic form that satisfies the requirements of paragraph (c) of this Q&A–13. First class mail to the last known address of the party is an acceptable delivery method. Likewise, hand delivery is acceptable. However, the posting of notice is not considered provision of section 204(h) notice. Section 204(h) notice may be enclosed with or combined with other notice provided by the employer or plan administrator (for example, a notice of intent to terminate under title IV of ERISA). Except as provided in paragraph (c) of this Q&A–13, a section 204(h) notice is deemed to have been provided on a date if it has been provided by the end of that day. When notice is delivered by first class mail, the notice is considered provided as of the date of the United States postmark stamped on the cover in which the document is mailed.

(b) *Example.* The following example illustrates the provisions of paragraph (a) of this Q&A–13:

Example. (i) *Facts.* Plan A is amended to reduce significantly the rate of future benefit accrual effective January 1, 2005. Under Q&A–9 of this section, section 204(h) notice is required to be provided at least 45 days before the effective date of the amendment. The plan administrator causes section 204(h) notice to be mailed to all affected participants. The mailing is postmarked November 16, 2004.

(ii) *Conclusion.* Because section 204(h) notice is given 45 days before the effective date of the plan amendment, it satisfies the timing requirement of Q&A–9 of this section.

(c) *New technologies*—(1) *General rule.* A section 204(h) notice may be provided to an applicable individual through an electronic method (other than an oral communication or a recording of an oral communication), provided that all of the following requirements are satisfied:

(i) Either the notice is actually received by the applicable individual or the plan administrator takes appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice by the applicable individual.

(ii) The section 204(h) notice is delivered using an electronic medium (other than an oral communication or a recording of an oral communication) under an electronic system that satisfies the applicable notice requirements of § 1.401(a)–21.

(iii) *Special effective date.* For plan years beginning prior to January 1, 2007, Q&A–13 of this section, as it appeared in the April 1, 2006 edition of 26 CFR part 1, applies.

(2) *Examples.* The following examples illustrate the requirement in paragraph (c)(1)(i) of this Q&A–13. In these examples, it is assumed that the notice satisfies the requirements in paragraphs (c)(1)(ii) of this section. The examples are as follows:

Example 1. (i) *Facts.* On July 1, 2003, M, a plan administrator of Company N's plan, sends notice intended to constitute section 204(h) notice to A, an employee of Company N and a participant in the plan. The notice is sent through e-mail to A's e-mail address on Company N's electronic information system. Accessing Company N's electronic information system is not an integral part of A's duties. M sends the e-mail with a request for a computer-generated notification that the message was received and opened. M receives notification indicating that the e-mail was received and opened by A on July 9, 2003.

(ii) *Conclusion*. With respect to A, although M has failed to take appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice, M satisfies the requirement of paragraph (c)(1)(i) of this Q&A–13 on July 9, 2003, which is when A actually receives the notice.

Example 2. (i) *Facts*. On August 1, 2003, O, a plan administrator of Company P's plan, sends a notice intended to constitute section 204(h) notice of ERISA to B, who is an employee of Company P and a participant in Company P's plan. The notice is sent through e-mail to B's e-mail address on Company P's electronic information system. B has the ability to effectively access electronic documents from B's e-mail address on Company P's electronic information system and accessing the system is an integral part of B's duties.

(ii) *Conclusion*. Because access to the system is an integral part of B's duties, O has taken appropriate and necessary measures reasonably calculated to ensure that the method for providing section 204(h) notice results in actual receipt of the notice. Thus, regardless of whether B actually accesses B's email on that date, O satisfies the requirement of paragraph (c)(1)(i) of this Q&A–13 on August 1, 2003, with respect to B.

Q–14. What are the consequences if a plan administrator fails to provide section 204(h) notice?

A–14. (a) *Egregious failures*—(1) *Effect of egregious failure to provide section 204(h) notice*. Section 204(h)(6)(A) of ERISA provides that, in the case of any egregious failure to meet the notice requirements with respect to any plan amendment, the plan provisions are applied so that all applicable individuals are entitled to the greater of the benefit to which they would have been entitled without regard to the amendment, or the benefit under the plan with regard to the amendment. For a special rule applicable in the case of a plan termination, *see* Q&A–17(b) of this section.

(2) *Definition of egregious failure*. For purposes of section 204(h) of ERISA and this Q&A–14, there is an egregious failure to meet the notice requirements if a failure to provide required notice is within the control of the plan sponsor and is either an intentional failure or a failure, whether or not intentional, to provide most of the individuals with most of the information they are entitled to receive. For this purpose, an intentional failure includes any failure to promptly provide the required notice or information after the plan administrator discovers an unintentional failure to meet the requirements. A failure to give section 204(h) notice is deemed not to be egregious if the plan administrator reasonably determines, taking into account section 4980F, section 204(h), these regulations, other administrative pronouncements, and relevant facts and circumstances, that the reduction in the rate of future benefit accrual resulting from an amendment is not significant (as described in Q&A–8 of this section), or that an amendment does not significantly reduce an early retirement benefit or retirement-type subsidy.

(3) Example. The following example illustrates the provisions of this paragraph (a):

Example. (i) *Facts*. Plan A is amended to reduce significantly the rate of future benefit accrual effective January 1, 2003. Section 204(h) notice is required to be provided 45 days before January 1, 2003. Timely section 204(h) notice is provided to all applicable individuals (and to each employee organization representing participants who are applicable individuals), except that the employer intentionally fails to provide section 204(h) notice to certain participants until May 16, 2003.

(ii) *Conclusion*. The failure to provide section 204(h) notice is egregious. Accordingly, for the period from January 1, 2003 through June 30, 2003 (which is the date that is 45 days after May 16, 2003), all participants and alternate payees are entitled to the greater of the benefit to which they would have been entitled under Plan A as in effect before the amendment or the benefit under the plan as amended.

(b) *Effect of non-egregious failure to provide section 204(h) notice*. If an egregious failure has not occurred, the amendment with respect to which section 204(h) notice is required may become effective with respect to all applicable individuals. However, see section 502 of ERISA for civil enforcement remedies. Thus, where there is a failure, whether or not egregious, to provide section 204(h) notice in accordance with this section, individuals may have recourse under section 502 of ERISA.

(c) *Excise taxes*. See section 4980F and Q&A–15 of this section for excise taxes that may apply to a failure to notify applicable individuals of a pension plan amendment that provides for a significant reduction in the rate of future

benefit accrual or eliminates or significantly reduces an early retirement benefit or retirement-type subsidy, regardless of whether or not the failure is egregious.

Q–15. What are some of the rules that apply with respect to the excise tax under section 4980F?

A–15. (a) *Person responsible for excise tax*. In the case of a plan other than a multiemployer plan, the employer is responsible for reporting and paying the excise tax. In the case of a multiemployer plan, the plan is responsible for reporting and paying the excise tax.

(b) *Excise tax inapplicable in certain cases*. Under section 4980F(c)(1) of the Internal Revenue Code, no excise tax is imposed on a failure for any period during which it is established to the satisfaction of the Commissioner that the employer (or other person responsible for the tax) exercised reasonable diligence, but did not know that the failure existed. Under section 4980F(c)(2) of the Internal Revenue Code, no excise tax applies to a failure to provide section 204(h) notice if the employer (or other person responsible for the tax) exercised reasonable diligence and corrects the failure within 30 days after the employer (or other person responsible for the tax) first knew, or exercising reasonable diligence would have known, that such failure existed. For purposes of section 4980F(c)(1) of the Internal Revenue Code, a person has exercised reasonable diligence, but did not know that the failure existed if and only if—

(1) The person exercised reasonable diligence in attempting to deliver section 204(h) notice to applicable individuals by the latest date permitted under this section; and

(2) At the latest date permitted for delivery of section 204(h) notice, the person reasonably believes that section 204(h) notice was actually delivered to each applicable individual by that date.

(c) *Example*. The following example illustrates the provisions of paragraph (b) of this Q&A–15:

Example. (i) *Facts*. Plan A is amended to reduce significantly the rate of future benefit accrual. The employer sends out a section 204(h) notice to all affected participants and other applicable individuals and to any employee organization representing applicable individuals, including actual delivery by hand to employees at worksites and by first-class mail for any other applicable individual and to any employee organization representing applicable individuals. However, although the employer exercises reasonable diligence in seeking to deliver the notice, the notice is not delivered to any participants at one worksite due to a failure of an overnight delivery service to provide the notice to appropriate personnel at that site for them to timely hand deliver the notice to affected employees. The error is discovered when the employer subsequently calls to confirm delivery. Appropriate section 204(h) notice is then promptly delivered to all affected participants at the worksite.

(ii) *Conclusion*. Because the employer exercised reasonable diligence, but did not know that a failure existed, no excise tax applies, assuming that participants at the worksite receive section 204(h) notice within 30 days after the employer first knew, or exercising reasonable diligence would have known, that the failure occurred.

Q–16. How do section 4980F and section 204(h) apply when a business is sold?

A–16. (a) *Generally*. Whether section 204(h) notice is required in connection with the sale of a business depends on whether a plan amendment is adopted that significantly reduces the rate of future benefit accrual or significantly reduces an early retirement benefit or retirement-type subsidy.

(b) *Examples*. The following examples illustrate the rules of this Q&A–16:

Example 1. (i) *Facts*. Corporation Q maintains Plan A, a defined benefit plan that covers all employees of Corporation Q, including employees in its Division M. Plan A provides that participating employees cease to accrue benefits when they cease to be employees of Corporation Q. On January 1, 2006, Corporation Q sells all of the assets of Division M to Corporation R. Corporation R maintains Plan B, which covers all of the employees of Corporation R. Under the sale agreement, employees of Division M become employees of Corporation R on the date of the sale (and cease to be employees of Corporation Q), Corporation Q continues to maintain Plan A following the sale, and the employees of Division M become participants in Plan B.

(ii) *Conclusion*. No section 204(h) notice is required because no plan amendment was adopted that reduced the rate of future benefit accrual. The employees of Division M who become employees of Corporation R ceased to accrue benefits under Plan A because their employment with Corporation Q terminated.

Example 2. (i) *Facts.* Subsidiary Y is a wholly owned subsidiary of Corporation S. Subsidiary Y maintains Plan C, a defined benefit plan that covers employees of Subsidiary Y. Corporation S sells all of the stock of Subsidiary Y to Corporation T. At the effective date of the sale of the stock of Subsidiary Y, in accordance with the sale agreement between Corporation S and Corporation T, Subsidiary Y amends Plan C so that all benefit accruals cease.

(ii) *Conclusion.* Section 204(h) notice is required to be provided because Subsidiary Y adopted a plan amendment that significantly reduced the rate of future benefit accrual in Plan C.

Example 3. (i) *Facts.* As a result of an acquisition, Corporation U maintains two defined benefit plans: Plan D covers employees of Division N and Plan E covers the rest of the employees of Corporation U. Plan E provides a significantly lower rate of future benefit accrual than Plan D. Plan D is merged with Plan E, and all of the employees of Corporation U will accrue benefits under the merged plan in accordance with the benefit formula of former Plan E.

(ii) *Conclusion.* Section 204(h) notice is required.

Example 4. (i) *Facts.* The facts are the same as in *Example 3,* except that the rate of future benefit accrual in Plan E is not significantly lower. In addition, Plan D has a retirement-type subsidy that Plan E does not have and the Plan D employees' rights to the subsidy under the merged plan are limited to benefits accrued before the merger.

(ii) *Conclusion.* Section 204(h) notice is required for any participants or beneficiaries for whom the reduction in the retirement-type subsidy is significant (and for any employee organization representing such participants).

Example 5. (i) *Facts.* Corporation V maintains several plans, including Plan F, which covers employees of Division P. Plan F provides that participating employees cease to accrue further benefits under the plan when they cease to be employees of Corporation V. Corporation V sells all of the assets of Division P to Corporation W, which maintains Plan G for its employees. Plan G provides a significantly lower rate of future benefit accrual than Plan F. Plan F is merged with Plan G as part of the sale, and employees of Division P who become employees of Corporation W will accrue benefits under the merged plan in accordance with the benefit formula of former Plan G.

(ii) *Conclusion.* No section 204(h) notice is required because no plan amendment was adopted that reduces the rate of future benefit accrual or eliminates or significantly reduces an early retirement benefit or retirement-type subsidy. Under the terms of Plan F as in effect prior to the merger, employees of Division P cease to accrue any further benefits (including benefits with respect to early retirement benefits and any retirement-type subsidy) under Plan F after the date of the sale because their employment with Corporation V terminated.

Q–17. How are amendments to cease accruals and terminate a plan treated under section 4980F and section 204(h)?

A–17. (a) *General rule*—(1) *Rule.* An amendment providing for the cessation of benefit accruals on a specified future date and for the termination of a plan is subject to section 4980F and section 204(h).

(2) *Example.* The following example illustrates the rule of paragraph (a)(1) of this Q&A–17:

Example. (i) *Facts.* An employer adopts an amendment that provides for the cessation of benefit accruals under a defined benefit plan on December 31, 2003, and for the termination of the plan pursuant to title IV of ERISA as of a proposed termination date that is also December 31, 2003. As part of the notice of intent to terminate required under title IV in order to terminate the plan, the plan administrator gives section 204(h) notice of the amendment ceasing accruals, which states that benefit accruals will cease ''on December 31, 2003 whether or not the plan is terminated on that date.'' However, because all the requirements of title IV for a plan termination are not satisfied, the plan cannot be terminated until a date that is later than December 31, 2003.

(ii) *Conclusion.* Nonetheless, because section 204(h) notice was given stating that the plan was amended to cease accruals on December 31, 2003, section 204(h) does not prevent the amendment to cease accruals from being effective on December 31, 2003. The result would be the same had the section 204(h) notice informed the participants that the plan was amended to provide for a proposed termination date of December 31, 2003 and to provide that ''benefit accruals will cease on the proposed termination date whether or not the plan is terminated on that date.'' However, neither section 4980F nor section 204(h) would be satisfied with respect to the December 31, 2003 effective date if the section 204(h) notice had merely stated that benefit accruals would cease ''on the termination date'' or ''on the proposed termination date.''

(3) *Additional requirements under title IV of ERISA. See* 29 CFR 4041.23(b)(4) and 4041.43(b)(5) for special rules applicable to plans terminating under title IV of ERISA.

(b) *Terminations in accordance with title IV of ERISA.* A plan that is terminated in accordance with title IV of

ERISA is deemed to have satisfied section 4980F and section 204(h) not later than the termination date (or date of termination, as applicable) established under section 4048 of ERISA. Accordingly, neither section 4980F nor section 204(h) would in any event require that any additional benefits accrue after the effective date of the termination.

(c) *Amendment effective before termination date of a plan subject to title IV of ERISA.* To the extent that an amendment providing for a significant reduction in the rate of future benefit accrual or a significant reduction in an early retirement benefit or retirement-type subsidy has an effective date that is earlier than the termination date (or date of termination, as applicable) established under section 4048 of ERISA, that amendment is subject to section 4980F and section 204(h). Accordingly, the plan administrator must provide section 204(h) notice (either separately, with, or as part of the notice of intent to terminate) with respect to such an amendment.

Q–18. What are the effective dates of section 4980F, section 204(h), as amended by EGTRRA, and these regulations?

A–18. (a) *Statutory effective date*—(1) *General rule.* Section 4980F and section 204(h), as amended by EGTRRA, apply to plan amendments taking effect on or after June 7, 2001 (statutory effective date), which is the date of enactment of EGTRRA.

(2) *Transition rule.* For amendments applying after the statutory effective date in paragraph (a)(1) of this Q&A–18 and prior to the regulatory effective date in paragraph (c) of this Q&A–18, the requirements of section 4980F(e)(2) and (3) of the Internal Revenue Code and section 204(h), as amended by EGTRRA, are treated as satisfied if the plan administrator makes a reasonable, good faith effort to comply with those requirements.

(3) *Special notice rule*—(i) *In general.* Notwithstanding Q&A–9 of this section, section 204(h) notice is not required by section 4980F(e) of the Internal Revenue Code or section 204(h), as amended by EGTRRA, to be provided prior to September 7, 2001 (the date that is three months after the date of enactment of EGTRRA).

(ii) *Reasonable notice.* The requirements of section 4980F and section 204(h), as amended by EGTRRA, do not apply to any plan amendment that takes effect on or after June 7, 2001 if, before April 25, 2001, notice was provided to participants and beneficiaries adversely affected by the plan amendment (and their representatives) which was reasonably expected to notify them of the nature and effective date of the plan amendment. For purposes of this paragraph (a)(3)(ii), notice that complies with §1.411(d)–6 of this chapter, as it appeared in the April 1, 2001 edition of 26 CFR part 1, is deemed to be notice which was reasonably expected to notify participants and beneficiaries adversely affected by the plan amendment (and their representatives) of the nature and effective date of the plan amendment.

(4) *Special effective date for certain section 204(h) amendments made by plans of commercial airlines.* Section 402 of PPA '06 applies to section 204(h) amendments adopted in plan years ending after August 17, 2006.

(5) *Special effective date for rule relating to contributing employers.* Section 502(c) of PPA '06, which amended section 4980F(e)(1) of the Internal Revenue Code, applies to section 204(h) amendments adopted in plan years beginning after December 31, 2007.

(b) *Regulatory effective date*—(1) *General effective date.* Except as otherwise provided in this paragraph (b) of this section, Q&A–1 through Q&A–18 of this section apply to amendments with an effective date that is on or after September 1, 2003.

(2) *Effective date for Q&A–7(a)(2).* Q&A–7(a)(2) of this section applies to amendments with an effective date that is on or after January 1, 2004.

(3) *Effective dates for Q&A–9(g)(1), (g)(3), and (g)(4)*—(i) *General effective date.* Except as otherwise provided in Q&A–18(b)(3)(ii) or (b)(3)(iii) of this section, Q&A–9(g)(1), (g)(3), and (g)(4) of this section apply to amendments that are effective on or after January 1, 2008.

(ii) *Effective dates for Q&A–9(g)(2) and Q&A–7(b).* Except as otherwise provided in Q&A–18(b)(3)(iii) of this section,

Q&A–9(g)(2) and Q&A–7(b) of this section apply to section 204(h) amendments adopted in plan years beginning after July 1, 2008.

(iii) *Special rules for section 204(h) amendments to an applicable defined benefit plan.* Except as otherwise provided in paragraph (b)(3)(i) or (b)(3)(ii) of this Q&A–18, with respect to any section 204(h) notice provided in connection with a section 204(h) amendment to an applicable defined benefit plan within the meaning of section 411(a)(13)(C)(i) to limit distributions as permitted under section 411(a)(13)(A) for distributions made after August 17, 2006, that is made pursuant to section 701 of PPA '06, paragraphs (g)(1) and (g)(2) of Q&A–9 of this section apply to amendments that are effective after December 21, 2006. For such an amendment that is effective not later than December 31, 2008, section 204(h) notice does not fail to be timely if the notice is provided at least 30 days, rather than 45 days, before the date that the amendment is first effective.

(c) *Amendments taking effect prior to June 7, 2001.* For rules applicable to amendments taking effect prior to June 7, 2001, *see* § 1.411(d)–6 of this chapter, as it appeared in the April 1, 2001 edition of 26 CFR part 1.

[T.D. 9052, 68 FR 17281, Apr. 9, 2003, as amended by T.D. 9219, 70 FR 47126, Aug. 12, 2005; T.D. 9294, 71 FR 61888, Oct. 20, 2006; T.D. 9472, 74 FR 61276, Nov. 24, 2009]

§ 54.4980G–0 Table of contents.

This section contains the questions for §§ 54.4980G–1, 54.4980G–2, 54.4980G–3, 54.4980G–4, and 54.4980G–5.

§ 54.4980G–1 Failure of employer to make comparable health savings account contributions.

Q–1: What are the comparability rules that apply to employer contributions to Health Savings Accounts (HSAs)?

Q–2: What are the categories of HDHP coverage for purposes of applying the comparability rules?

Q–3: What is the testing period for making comparable contributions to employees' HSAs?

Q–4: How is the excise tax computed if employer contributions do not satisfy the comparability rules for a calendar year?

§ 54.4980G–2 Employer contribution defined.

Q–1: Do the comparability rules apply to amounts rolled over from an employee's HSA or Archer Medical Savings Account (Archer MSA)?

Q–2: If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the comparability rules apply to these amounts?

§ 54.4980G–3 Employee for comparability testing.

Q–1: Do the comparability rules apply to contributions that an employer makes to the HSAs of independent contractors or self-employed individuals?

Q–2: May a sole proprietor who is an eligible individual contribute to his or her own HSA without contributing to the HSAs of his or her employees who are eligible individuals?

Q–3: Do the comparability rules apply to contributions by a partnership to a partner's HSA?

Q–4: How are members of controlled groups treated when applying the comparability rules?

Q–5: What are the categories of employees for comparability testing?

Q–6: Are employees who are included in a unit of employees covered by a collective bargaining agreement comparable participating employees?

Q–7: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating employees who have coverage under the employer's HDHP?

Q–8: If an employee and his or her spouse are eligible individuals who work for the same employer and one employee-spouse has family coverage for both employees under the employer's HDHP, must the employer make comparable contributions to the HSAs of both employees?

Q–9: Does an employer that makes HSA contributions only for one class of non-collectively bargained employees who are eligible individuals, but not for another class of non-collectively bargained employees who are eligible individuals (for example, management v. non-management) satisfy the requirement that the employer make comparable contributions?

Q–10: If an employer contributes to the HSAs of former employees who are eligible individuals, do the comparability rules apply to these contributions?

Q–11: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating former employees who have coverage under the employer's HDHP?

Q–12: If an employer contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP, must the employer make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1))?

Q–13: How do the comparability rules apply if some employees have HSAs and other employees have Archer MSAs?

§ 54.4980G–4 Calculating comparable contributions.

Q–1: What are comparable contributions?

Q–2: How does an employer comply with the comparability rules when some non-collectively bargained employees who are eligible individuals do not work for the employer during the entire calendar year?

Q–3: How do the comparability rules apply to employer contributions to employees' HSAs if some non-collectively bargained employees work full-time during the entire calendar year, and other non-collectively bargained employees work full-time for less than the entire calendar year?

Q–4: May an employer make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year (*i.e.*, on a prefunded basis) instead of contributing on a pay-as-you-go or on a look-back basis?

Q–5: Must an employer use the same contribution method as described in Q & A–2 and Q & A–4 of this section for all employees for any month during the calendar year?

Q–6: How does an employer comply with the comparability rules if an employee has not established an HSA at the time the employer contributes to its employees' HSAs?

Q–7: If an employer bases its contributions on a percentage of the HDHP deductible, how is the correct percentage or dollar amount computed?

Q–8: Does an employer that contributes to the HSA of each comparable participating employee in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (matching contributions) satisfy the rule that all comparable participating employees receive comparable contributions?

Q–9: If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the comparability rules?

Q–10: If an employer makes additional contributions to the HSAs of all comparable participating employees who have attained a specified age or who have worked for the employer for a specified number of years, do the contributions satisfy the comparability rules?

Q–11: If an employer makes additional contributions to the HSAs of all comparable participating employees who are eligible to make the additional contributions (HSA catch-up contributions) under section 223(b)(3), do the contributions satisfy the comparability rules?

Q–12: If an employer's contributions to an employee's HSA result in non-comparable contributions, may the employer recoup the excess amount from the employee's HSA?

Q–13: What constitutes a reasonable interest rate for purposes of making comparable contributions?

Q–14: How does an employer comply with the comparability rules if an employee has not established an HSA by December 31st?

Q–15: For any calendar year, may an employer accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses (as defined in section 223(d)(2)) exceeding the employer's cumulative HSA contributions at that time?

Q–16: What is the effective date for the rules in Q & A–14 and Q & A–15 of this section?

§ 54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.

Q–1: If an employer makes contributions through a section 125 cafeteria plan to the HSA of each employee who is an eligible individual, are the contributions subject to the comparability rules?

Q–2: If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (*i.e.*, matching contributions), are the contributions subject to the section 4980G comparability rules?

Q–3: If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA and the employees have the right to elect to make pre-tax salary reduction contributions to their HSAs, are the contributions subject to the comparability rules?

Q–4: May all or part of the excise tax imposed under section 4980G be waived?

[T.D. 9277, 71 FR 43058, July 31, 2006; 71 FR 53967, Sept. 13, 2006, as amended by T.D. 9393, 73 FR 20795, Apr. 17, 2008]

§ 54.4980G–1 Failure of employer to make comparable health savings account contributions.

Q–1: What are the comparability rules that apply to employer contributions to Health Savings Accounts (HSAs)?

A–1: If an employer makes contributions to any employee's HSA, the employer must make comparable contributions to the HSAs of all comparable participating employees. See Q & A–1 in § 54.4980G–4 for the definition of comparable contributions. Comparable participating employees are eligible individuals (as defined in section 223(c)(1)) who are in the same category of employees and who have the same category of high deductible health plan (HDHP) coverage. See sections 4980G(b) and 4980E(d)(3). See section 223(c)(2) and (g) for the definition of an HDHP. See also Q & A–5 in § 54.4980G–3 for the categories of employees and Q & A–2 of this section for the categories of HDHP coverage. But *see* Q & A–6 in § 54.4980G–3 for treatment of collectively bargained employees and Q & A–1 in § 54.4980G–6 for the rules allowing larger comparable contributions to nonhighly compensated employees.

Q–2: What are the categories of HDHP coverage for purposes of applying the comparability rules?

A–2: (a) *In general*. Generally, the categories of coverage are self-only HDHP coverage and family HDHP coverage. Family HDHP coverage means any coverage other than self-only HDHP coverage. The comparability rules apply separately to self-only HDHP coverage and family HDHP coverage. In addition, if an HDHP has family coverage options meeting the descriptions listed in paragraph (b) of this Q & A–2, each such coverage option may be treated as a separate category of coverage and the comparability rules may be applied separately to each category. However, if the HDHP has more than one category that provides coverage for the same number of individuals, all such categories are treated as a single category for purposes of the comparability rules. Thus, the categories of ''employee plus spouse'' and ''employee plus dependent,'' each providing coverage for two individuals, are treated as the single category ''self plus one'' for comparability purposes. See, however, the final sentence of paragraph (a) of Q & A–1 of § 54.4980G–4 for a special rule that applies if different amounts are contributed for different categories of family coverage. *See also* § 54.4980G–6 for the rules allowing larger comparable contributions to nonhighly compensated employees.

(b) *HDHP Family coverage categories*. The coverage categories are—

(1) Self plus one;

(2) Self plus two; and

(3) Self plus three or more.

(c) *Examples*. The rules of this Q & A–2 are illustrated by the following examples:

Example 1. Employer A maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has self-only coverage and family coverage. Thus, the categories of coverage are self-only and family coverage. Employer A contributes $750 to the HSA of each eligible employee with self-only HDHP coverage and $1,000 to the HSA of each eligible employee with family HDHP coverage. Employer A's contributions satisfy the comparability rules.

Example 2. (i) Employer B maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

(A) Self-only;

(B) Self plus spouse;

(C) Self plus dependent;

(D) Self plus spouse plus one dependent;

(E) Self plus two dependents; and

(F) Self plus spouse and two or more dependents.

(ii) The self plus spouse category and the self plus dependent category constitute the same category of HDHP coverage (self plus one) and Employer B must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse category of HDHP coverage or the self plus dependent category of HDHP coverage. Likewise, the self plus spouse plus one dependent category and the self plus two dependents category constitute the same category of HDHP coverage (self plus two) and Employer B must make the same comparable contributions to the HSAs of all eligible individuals who are in either the self plus spouse plus one dependent category of HDHP coverage or the self plus two dependents category of HDHP coverage.

Example 3. (i) Employer C maintains an HDHP and contributes to the HSAs of eligible employees who elect coverage under the HDHP. The HDHP has the following coverage options:

(A) Self-only;

(B) Self plus one;

(C) Self plus two; and

(D) Self plus three or more.

(ii) Employer C contributes $500 to the HSA of each eligible employee with self-only HDHP coverage, $750 to the HSA of each eligible employee with self plus one HDHP coverage, $900 to the HSA of each eligible employee with self plus two HDHP coverage and $1,000 to the HSA of each eligible employee with self plus three or more HDHP coverage. Employer C's contributions satisfy the comparability rules.

Q–3: What is the testing period for making comparable contributions to employees' HSAs?

A–3: To satisfy the comparability rules, an employer must make comparable contributions for the calendar year to the HSAs of employees who are comparable participating employees. See section 4980G(a). See Q & A–3 and Q & A–4 in § 54.4980G–4 for a discussion of HSA contribution methods.

Q–4: How is the excise tax computed if employer contributions do not satisfy the comparability rules for a calendar year?

A–4: (a) *Computation of tax*. If employer contributions do not satisfy the comparability rules for a calendar year, the employer is subject to an excise tax equal to 35% of the aggregate amount contributed by the employer to HSAs for that period.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–4:

Example. During the 2007 calendar year, Employer D has 8 employees who are eligible individuals with self-only coverage under an HDHP provided by Employer D. The deductible for the HDHP is $2,000. For the 2007 calendar year, Employer D contributes $2,000 each to the HSAs of two employees and $1,000 each to the HSAs of the other six employees, for total HSA contributions of $10,000. Employer D's contributions do not satisfy the comparability rules. Therefore, Employer D is subject to an excise tax of $3,500 (35% of $10,000) for its failure to make comparable contributions to its employees' HSAs.

Q–5: If a person is liable for the excise tax under section 4980G, what form must the person file and what is the due date for the filing and payment of the excise tax?

A–5: (a) *In general*. §§ 54.6011–2, 54.6151–1 and 54.6071–1(d).

(b) *Effective/applicability date*. The rules in this Q & A–5 are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9277, 71 FR 43058, July 31, 2006, as amended by T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980G–2 Employer contribution defined.

Q–1: Do the comparability rules apply to amounts rolled over from an employee's HSA or Archer Medical Savings Account (Archer MSA)?

A–1: No. The comparability rules do not apply to amounts rolled over from an employee's HSA or Archer MSA.

Q–2: If an employee requests that his or her employer deduct after-tax amounts from the employee's compensation and forward these amounts as employee contributions to the employee's HSA, do the comparability rules apply to these amounts?

A–2: No. Section 106(d) provides that amounts contributed by an employer to an eligible employee's HSA shall be treated as employer-provided coverage for medical expenses and are excludible from the employee's gross income up to the limit in section 223(b). After-tax employee contributions to an HSA are not subject to the comparability rules because they are not employer contributions under section 106(d).

[T.D. 9277, 71 FR 43058, July 31, 2006]

§ 54.4980G–3 Failure of employer to make comparable health savings account contributions.

Q–1: Do the comparability rules apply to contributions that an employer makes to the HSAs of independent contractors or self-employed individuals?

A–1: No. The comparability rules apply only to contributions that an employer makes to the HSAs of employees.

Q–2: May a sole proprietor who is an eligible individual contribute to his or her own HSA without contributing to the HSAs of his or her employees who are eligible individuals?

A–2: (a) *Sole proprietor not an employee*. Yes. The comparability rules apply only to contributions made by an employer to the HSAs of employees.

Because a sole proprietor is not an employee, the comparability rules do not apply to contributions the sole proprietor makes to his or her own HSA. However, if a sole proprietor contributes to any employee's HSA, the sole proprietor must make comparable contributions to the HSAs of all comparable participating employees. In determining whether the comparability rules are satisfied, contributions that a sole proprietor makes to his or her own HSA are not taken into account.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–2:

Example. In a calendar year, B, a sole proprietor is an eligible individual and contributes $1,000 to B's own HSA. B also contributes $500 for the same calendar year to the HSA of each employee who is an eligible individual. The comparability rules are not violated by B's $1,000 contribution to B's own HSA.

Q–3: Do the comparability rules apply to contributions by a partnership to a partner's HSA?

A–3: (a) *Partner not an employee*. No. Contributions by a partnership to a bona fide partner's HSA are not subject to the comparability rules because the contributions are not contributions by an employer to the HSA of an employee. The contributions are treated as either guaranteed payments under section 707(c) or distributions under section 731. However, if a partnership contributes to the HSAs of any employee who is not a partner, the partnership must make comparable contributions to the HSAs of all comparable participating employees.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–3:

Example. (i) Partnership X is a limited partnership with three equal individual partners, A (a general partner), B (a limited partner), and C (a limited partner). C is to be paid $300 annually for services rendered to Partnership X in her capacity as a partner without regard to partnership income (a section 707(c) guaranteed payment). D and E are the only employees of Partnership X and are not partners in Partnership X. A, B, C, D, and E are eligible individuals and each has an HSA. During Partnership X's Year 1 taxable year, which is also a calendar year, Partnership X makes the following contributions—

(A) A $300 contribution to each of A's and B's HSAs which are treated as section 731 distributions to A and B;

(B) A $300 contribution to C's HSA in lieu of paying C the guaranteed payment directly; and

(C) A $200 contribution to each of D's and E's HSAs, who are comparable participating employees.

(ii) Partnership X's contributions to A's and B's HSAs are section 731 distributions, which are treated as cash distributions. Partnership X's contribution to C's HSA is treated as a guaranteed payment under section 707(c). The contribution is not excludible from C's gross income under section 106(d) because the contribution is treated as a distributive share of partnership income for purposes of all Code sections other than sections 61(a) and 162(a), and a guaranteed payment to a partner is not treated as compensation to an employee. Thus, Partnership X's contributions to the HSAs of A, B, and C are not subject to the comparability rules. Partnership X's contributions to D's and E's HSAs are subject to the comparability rules because D and E are employees of Partnership X and are not partners in Partnership X. Partnership X's contributions satisfy the comparability rules.

Q–4: How are members of controlled groups treated when applying the comparability rules?

A–4: All persons or entities treated as a single employer under section 414 (b), (c), (m), or (o) are treated as one employer. See sections 4980G(b) and 4980E(e).

Q–5: What are the categories of employees for comparability testing?

A–5: (a) *Categories*. The categories of employees for comparability testing are as follows (but *see* Q & A–6 of this section for the treatment of collectively bargained employees and Q & A–1 of § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees)—

(1) Current full-time employees;

(2) Current part-time employees; and

(3) Former employees (except for former employees with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)).

(b) *Part-time and full-time employees*. For purposes of section 4980G, part-time employees are customarily employed for fewer than 30 hours per week and full-time employees are customarily employed for 30 or more hours per

week. See sections 4980G(b) and 4980E(d)(4)(A) and (B).

(c) *In general.* Except as provided in Q & A–6 of this section, the categories of employees in paragraph (a) of this Q & A–5 are the exclusive categories of employees for comparability testing. An employer must make comparable contributions to the HSAs of all comparable participating employees (eligible individuals who are in the same category of employees with the same category of HDHP coverage) during the calendar year without regard to any classification other than these categories. For example, full-time eligible employees with self-only HDHP coverage and part-time eligible employees with self-only HDHP coverage are separate categories of employees and different amounts can be contributed to the HSAs for each of these categories. But *see* § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

Q–6: Are employees who are included in a unit of employees covered by a collective bargaining agreement comparable participating employees?

A–6: (a) *In general.* No. Collectively bargained employees who are covered by a bona fide collective bargaining agreement between employee representatives and one or more employers are not comparable participating employees, if health benefits were the subject of good faith bargaining between such employee representatives and such employer or employers. Former employees covered by a collective bargaining agreement also are not comparable participating employees.

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–6. The examples read as follows:

Example 1. Employer A offers its employees an HDHP with a $1,500 deductible for self-only coverage. Employer A has collectively bargained and non-collectively bargained employees. The collectively bargained employees are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year, Employer A contributes $500 to the HSAs of all eligible non-collectively bargained employees with self-only coverage under Employer A's HDHP. Employer A does not contribute to the HSAs of the collectively bargained employees. Employer A's contributions to the HSAs of non-collectively bargained employees satisfy the comparability rules. The comparability rules do not apply to collectively bargained employees.

Example 2. Employer B offers its employees an HDHP with a $1,500 deductible for self-only coverage. Employer B has collectively bargained and non-collectively bargained employees. The collectively bargained employees are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year and in accordance with the terms of the collective bargaining agreement, Employer B contributes to the HSAs of all eligible collectively bargained employees. Employer B does not contribute to the HSAs of the non-collectively bargained employees. Employer B's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees. Accordingly, Employer B's failure to contribute to the HSAs of the non-collectively bargained employees does not violate the comparability rules.

Example 3. Employer C has two units of collectively bargained employees—unit Q and unit R—each covered by a collective bargaining agreement under which health benefits were bargained in good faith. In the 2007 calendar year and in accordance with the terms of the collective bargaining agreement, Employer C contributes to the HSAs of all eligible collectively bargained employees in unit Q. In accordance with the terms of the collective bargaining agreement, Employer C makes no HSA contributions for collectively bargained employees in unit R. Employer C's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees.

Example 4. Employer D has a unit of collectively bargained employees that are covered by a collective bargaining agreement under which health benefits were bargained in good faith. In accordance with the terms of the collective bargaining agreement, Employer D contributes an amount equal to a specified number of cents per hour for each hour worked to the HSAs of all eligible collectively bargained employees. Employer D's contributions to the HSAs of collectively bargained employees are not subject to the comparability rules because the comparability rules do not apply to collectively bargained employees.

Q–7: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating employees who have coverage under the employer's HDHP?

A–7: (a) *Employer-provided HDHP coverage*. If during a calendar year, an employer contributes to the HSA of any employee who is an eligible individual covered under an HDHP provided by the employer, the employer is required to make comparable contributions to the HSAs of all comparable participating employees with coverage under any HDHP provided by the employer. An employer that contributes only to the HSAs of employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to HSAs of employees who are eligible individuals but are not covered under the employer's HDHP.

(b) *Non-employer provided HDHP coverage*. An employer that contributes to the HSA of any employee who is an eligible individual with coverage under any HDHP that is not an HDHP provided by the employer, must make comparable contributions to the HSAs of all comparable participating employees whether or not covered under the employer's HDHP. An employer that makes a reasonable good faith effort to identify all comparable participating employees with non-employer provided HDHP coverage and makes comparable contributions to the HSAs of such employees satisfies the requirements in paragraph (b) of this Q & A–7.

(c) *Examples*. The following examples illustrate the rules in this Q & A–7. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer E offers an HDHP to its full-time employees. Most full-time employees are covered under Employer E's HDHP and Employer E makes comparable contributions only to these employees' HSAs. Employee W, a full-time employee of Employer E and an eligible individual, is covered under an HDHP provided by the employer of W's spouse and not under Employer E's HDHP. Employer E is not required to make comparable contributions to W's HSA.

Example 2. In a calendar year, Employer F does not offer an HDHP. Several full-time employees of Employer F, who are eligible individuals, have HSAs. Employer F contributes to these employees' HSAs. Employer F must make comparable contributions to the HSAs of all full-time employees who are eligible individuals.

Example 3. In a calendar year, Employer G offers an HDHP to its full-time employees. Most full-time employees are covered under Employer G's HDHP and Employer G makes comparable contributions to these employees' HSAs and also to the HSAs of full-time employees who are eligible individuals and who are not covered under Employer G's HDHP. Employee S, a full-time employee of Employer G and a comparable participating employee, is covered under an HDHP provided by the employer of S's spouse and not under Employer G's HDHP. Employer G must make comparable contributions to S's HSA.

Q–8: If an employee and his or her spouse are eligible individuals who work for the same employer and one employee-spouse has family coverage for both employees under the employer's HDHP, must the employer make comparable contributions to the HSAs of both employees?

A–8: (a) *In general*. If the employer makes contributions only to the HSAs of employees who are eligible individuals covered under its HDHP where only one employee-spouse has family coverage for both employees under the employer's HDHP, the employer is not required to contribute to the HSAs of both employee-spouses. The employer is required to contribute to the HSA of the employee-spouse with coverage under the employer's HDHP, but is not required to contribute to the HSA of the employee-spouse covered under the employer's HDHP by virtue of his or her spouse's coverage. However, if the employer contributes to the HSA of any employee who is an eligible individual with coverage under an HDHP that is not an HDHP provided by the employer, the employer must make comparable contributions to the HSAs of both employee-spouses if they are both eligible individuals. If an employer is required to contribute to the HSAs of both employee-spouses, the employer is not required to contribute amounts in excess of the annual contribution limits in section 223(b).

(b) *Examples*. The following examples illustrate the rules in paragraph (a) of this Q & A–8. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer H offers an HDHP to its full-time employees. Most full-time employees are covered under Employer H's HDHP and Employer H makes comparable contributions only to these employees' HSAs. T and U are a married couple. Employee T, who is a full-time employee of Employer H and an eligible individual, has family coverage under Employer H's HDHP for T and T's spouse. Employee U, who is also a full-time employee of Employer H and an eligible individual, does not have coverage under Employer H's HDHP except as the spouse of Employee T. Employer H is required to make comparable contributions to T's HSA, but is not required to make comparable contributions to U's HSA.

Example 2. In a calendar year, Employer J offers an HDHP to its full-time employees. Most full-time employees are covered under Employer J's HDHP and Employer J makes comparable contributions to these employees' HSAs and to the HSAs of full-time employees who are eligible individuals but are not covered under Employer J's HDHP. R and S are a married couple. Employee S, who is a full-time employee of Employer J and an eligible individual, has family coverage under Employer J's HDHP for S and S's spouse. Employee R, who is also a full-time employee of Employer J and an eligible individual, does not have coverage under Employer J's HDHP except as the spouse of Employee S. Employer J must make comparable contributions to S's HSA and to R's HSA.

Q–9: Does an employer that makes HSA contributions only for one class of non-collectively bargained employees who are eligible individuals, but not for another class of non-collectively bargained employees who are eligible individuals (for example, management v. non-management) satisfy the requirement that the employer make comparable contributions?

A–9: (a) *Different classes of employees.* No. If the two classes of employees are comparable participating employees, the comparability rules are not satisfied. The only categories of employees for comparability purposes are current full-time employees, current part-time employees, and former employees. Collectively bargained employees are not comparable participating employees. But see Q & A–1 in 54.4980G–5 on contributions made through a cafeteria plan. *See* § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

(b) *Examples.* The following examples illustrate the rules in paragraph (a) of this Q & A–9. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer K maintains an HDHP covering all management and non-management employees. Employer K contributes to the HSAs of non-management employees who are eligible individuals covered under its HDHP. Employer K does not contribute to the HSAs of its management employees who are eligible individuals covered under its HDHP. The comparability rules are not satisfied.

Example 2. All of Employer L's employees are located in city X and city Y. In a calendar year, Employer L maintains an HDHP for all employees working in city X only. Employer L does not maintain an HDHP for its employees working in city Y. Employer L contributes $500 to the HSAs of city X employees who are eligible individuals with coverage under its HDHP. Employer L does not contribute to the HSAs of any of its city Y employees. The comparability rules are satisfied because none of the employees in city Y are covered under an HDHP of Employer L. (However, if any employees in city Y were covered by an HDHP of Employer L, Employer L could not fail to contribute to their HSAs merely because they work in a different city.)

Example 3. Employer M has two divisions—division N and division O. In a calendar year, Employer M maintains an HDHP for employees working in division N and division O. Employer M contributes to the HSAs of division N employees who are eligible individuals with coverage under its HDHP. Employer M does not contribute to the HSAs of division O employees who are eligible individuals covered under its HDHP. The comparability rules are not satisfied.

Q–10: If an employer contributes to the HSAs of former employees who are eligible individuals, do the comparability rules apply to these contributions?

A–10: (a) *Former employees.* Yes. The comparability rules apply to contributions an employer makes to former employees' HSAs. Therefore, if an employer contributes to any former employee's HSA, it must make comparable contributions to the HSAs of all comparable participating former employees (former employees who are eligible individuals with the same category of HDHP coverage). However, an employer is not required to make comparable contributions to the HSAs of former employees with coverage under the employer's HDHP because of an election under a COBRA continuation

provision (as defined in section 9832(d)(1)). See Q & A–5 and Q & A–12 of this section. The comparability rules apply separately to former employees because they are a separate category of covered employee. See Q & A–5 of this section. Also, former employees who were covered by a collective bargaining agreement immediately before termination of employment are not comparable participating employees. See Q & A–6 of this section.

(b) *Locating former employees*. An employer making comparable contributions to former employees must take reasonable actions to locate any missing comparable participating former employees. In general, such actions include the use of certified mail, the Internal Revenue Service Letter Forwarding Program or the Social Security Administration's Letter Forwarding Service.

(c) *Examples*. The following examples illustrate the rules in paragraph (a) of this Q & A–10. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In a calendar year, Employer N contributes $1,000 for the calendar year to the HSA of each current employee who is an eligible individual with coverage under any HDHP. Employer N does not contribute to the HSA of any former employee who is an eligible individual. Employer N's contributions satisfy the comparability rules.

Example 2. In a calendar year, Employer O contributes to the HSAs of current employees and former employees who are eligible individuals covered under any HDHP. Employer O contributes $750 to the HSA of each current employee with self-only HDHP coverage and $1,000 to the HSA of each current employee with family HDHP coverage. Employer O also contributes $300 to the HSA of each former employee with self-only HDHP coverage and $400 to the HSA of each former employee with family HDHP coverage. Employer O's contributions satisfy the comparability rules.

Q–11: Is an employer permitted to make comparable contributions only to the HSAs of comparable participating former employees who have coverage under the employer's HDHP?

A–11: If during a calendar year, an employer contributes to the HSA of any former employee who is an eligible individual covered under an HDHP provided by the employer, the employer is required to make comparable contributions to the HSAs of all former employees who are comparable participating former employees with coverage under any HDHP provided by the employer. An employer that contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to the HSAs of former employees who are eligible individuals and who are not covered under the employer's HDHP. However, an employer that contributes to the HSA of any former employee who is an eligible individual with coverage under an HDHP that is not an HDHP of the employer, must make comparable contributions to the HSAs of all former employees who are eligible individuals whether or not covered under an HDHP of the employer.

Q–12: If an employer contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP, must the employer make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1))?

A–12: No. An employer that contributes only to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP is not required to make comparable contributions to the HSAs of former employees who are eligible individuals with coverage under the employer's HDHP because of an election under a COBRA continuation provision (as defined in section 9832(d)(1)).

Q–13: How do the comparability rules apply if some employees have HSAs and other employees have Archer MSAs?

A–13: (a) *HSAs and Archer MSAs*. The comparability rules apply separately to employees who have HSAs and employees who have Archer MSAs. However, if an employee has both an HSA and an Archer MSA, the employer may contribute to either the HSA or the Archer MSA, but not to both.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–13:

Example. In a calendar year, Employer P contributes $600 to the Archer MSA of each employee who is an eligible individual and who has an Archer MSA. Employer P contributes $500 for the calendar year to the HSA of each employee who is an eligible individual and who has an HSA. If an employee has both an Archer MSA and an HSA, Employer P contributes to the employee's Archer MSA and not to the employee's HSA. Employee X has an Archer MSA and an HSA. Employer P contributes $600 for the calendar year to X's Archer MSA but does not contribute to X's HSA. Employer P's contributions satisfy the comparability rules.

[T.D. 9277, 71 FR 43058, July 31, 2006, as amended by T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–4 Calculating comparable contributions.

Q–1: What are comparable contributions?

A–1: (a) *Definition*. Contributions are comparable if, for each month in a calendar year, the contributions are either the same amount or the same percentage of the deductible under the HDHP for employees who are eligible individuals with the same category of coverage on the first day of that month. Employees with self-only HDHP coverage are tested separately from employees with family HDHP coverage. Similarly, employees with different categories of family HDHP coverage may be tested separately. See Q & A–2 in § 54.4980G–1. An employer is not required to contribute the same amount or the same percentage of the deductible for employees who are eligible individuals with one category of HDHP coverage that it contributes for employees who are eligible individuals with a different category of HDHP coverage. For example, an employer that satisfies the comparability rules by contributing the same amount to the HSAs of all employees who are eligible individuals with family HDHP coverage is not required to contribute any amount to the HSAs of employees who are eligible individuals with self-only HDHP coverage, or to contribute the same percentage of the self-only HDHP deductible as the amount contributed with respect to family HDHP coverage. However, the contribution with respect to the self plus two category may not be less than the contribution with respect to the self plus one category and the contribution with respect to the self plus three or more category may not be less than the contribution with respect to the self plus two category. But *see* Q & A–1 of § 54.4980G–6 for a special rule for contributions made to the HSAs of nonhighly compensated employees.

(b) *Examples*. The following examples illustrate the rules in paragraph (a) of this Q & A–1. None of the employees in the following examples are covered by a collective bargaining agreement. The examples read as follows:

Example 1. In the 2007 calendar year, Employer A offers its full-time employees three health plans, including an HDHP with self-only coverage and a $2,000 deductible. Employer A contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer A makes no HSA contributions for employees with family HDHP coverage or for employees who do not elect the employer's self-only HDHP. Employer A's HSA contributions satisfy the comparability rules.

Example 2. In the 2007 calendar year, Employer B offers its employees an HDHP with a $3,000 deductible for self-only coverage and a $4,000 deductible for family coverage. Employer B contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer B contributes $2,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer B's HSA contributions satisfy the comparability rules.

Example 3. In the 2007 calendar year, Employer C offers its employees an HDHP with a $1,500 deductible for self-only coverage and a $3,000 deductible for family coverage. Employer C contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer C contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual electing the family HDHP coverage. Employer C's HSA contributions satisfy the comparability rules.

Example 4. In the 2007 calendar year, Employer D offers its employees an HDHP with a $1,500 deductible for self-only coverage and a $3,000 deductible for family coverage. Employer D contributes $1,500 for the calendar year to the HSA of each employee who is an eligible individual electing the self-only HDHP coverage. Employer D contributes $1,000 for the calendar year to the HSA of each employee who is an eligible individual

electing the family HDHP coverage. Employer D's HSA contributions satisfy the comparability rules.

Example 5. (i) In the 2007 calendar year, Employer E maintains two HDHPs. Plan A has a $2,000 deductible for self-only coverage and a $4,000 deductible for family coverage. Plan B has a $2,500 deductible for self-only coverage and a $4,500 deductible for family coverage. For the calendar year, Employer E makes contributions to the HSA of each full-time employee who is an eligible individual covered under Plan A of $600 for self-only coverage and $1,000 for family coverage. Employer E satisfies the comparability rules, if it makes either of the following contributions for the 2007 calendar year to the HSA of each full-time employee who is an eligible individual covered under Plan B—

(A) $600 for each full-time employee with self-only coverage and $1,000 for each full-time employee with family coverage; or

(B) $750 for each employee with self-only coverage and $1,125 for each employee with family coverage (the same percentage of the deductible Employer E contributes for full-time employees covered under Plan A, 30% of the deductible for self-only coverage and 25% of the deductible for family coverage).

(ii) Employer E also makes contributions to the HSA of each part-time employee who is an eligible individual covered under Plan A of $300 for self-only coverage and $500 for family coverage. Employer E satisfies the comparability rules, if it makes either of the following contributions for the 2007 calendar year to the HSA of each part-time employee who is an eligible individual covered under Plan B—

(A) $300 for each part-time employee with self-only coverage and $500 for each part-time employee with family coverage; or

(B) $375 for each part-time employee with self-only coverage and $563 for each part-time employee with family coverage (the same percentage of the deductible Employer E contributes for part-time employees covered under Plan A, 15% of the deductible for self-only coverage and 12.5% of the deductible for family coverage).

Example 6. (i) In the 2007 calendar year, Employer F maintains an HDHP. The HDHP has the following coverage options—

(A) A $2,500 deductible for self-only coverage;

(B) A $3,500 deductible for self plus one dependent (self plus one);

(C) A $3,500 deductible for self plus spouse (self plus one);

(D) A $3,500 deductible for self plus spouse and one dependent (self plus two); and

(E) A $3,500 deductible for self plus spouse and two or more dependents (self plus three or more).

(ii) Employer F makes the following contributions for the calendar year to the HSA of each full-time employee who is an eligible individual covered under the HDHP—

(A) $750 for self-only coverage;

(B) $1,000 for self plus one dependent;

(C) $1,000 for self plus spouse;

(D) $1,500 for self plus spouse and one dependent; and

(E) $2,000 for self plus spouse and two or more dependents.

(iii) Employer F's HSA contributions satisfy the comparability rules.

Example 7. (i) In a calendar year, Employer G offers its employees an HDHP and a health flexible spending arrangement (health FSA). The health FSA reimburses employees for medical expenses as defined in section 213(d). Some of Employer G's employees have coverage under the HDHP and the health FSA, some have coverage under the HDHP and their spouse's FSA, and some have coverage under the HDHP and are enrolled in Medicare. For the calendar year, Employer G contributes $500 to the HSA of each employee who is an eligible individual. No contributions are made to the HSAs of employees who have coverage under Employer G's health FSA or under a spouse's health FSA or who are enrolled in Medicare.

(ii) The employees who have coverage under a health FSA (whether Employer H's or their spouse's FSA) or who are covered under Medicare are not eligible individuals. Specifically, the employees who have coverage under the health FSA or under a spouse's health FSA are not comparable participating employees because they are not eligible individuals under section 223(c)(1). Similarly, the employees who are enrolled in Medicare are not comparable participating employees because they are not eligible individuals under section 223(b)(7) and (c)(1). Therefore, employees who have coverage under the health FSA or under a spouse's health FSA and employees who are enrolled in Medicare are excluded from comparability testing. See sections 4980G(b) and 4980E. Employer G's contributions satisfy the comparability rules.

Q–2: How does an employer comply with the comparability rules when some non-collectively bargained employees who are eligible individuals do not work for the employer during the entire calendar year?

A–2: (a) *In general.* In determining whether the comparability rules are satisfied, an employer must take into account all full-time and part-time employees who were employees and eligible individuals for any month during the calendar year. (Full-time and part-time employees are tested separately. See Q & A–5 in § 54.4980G–3.) There are

two methods to comply with the comparability rules when some employees who are eligible individuals do not work for the employer during the entire calendar year; contributions may be made on a pay-as-you-go basis or on a look-back basis. See Q & A–9 through Q & A–11 in § 54.4980G–3 for the rules regarding comparable contributions to the HSAs of former employees.

(b) *Contributions on a pay-as-you-go basis*. An employer may comply with the comparability rules by contributing amounts at one or more dates during the calendar year to the HSAs of employees who are eligible individuals as of the first day of the month, if contributions are the same amount or the same percentage of the HDHP deductible for employees who are eligible individuals as of the first day of the month with the same category of coverage and are made at the same time. Contributions made at the employer's usual payroll interval for different groups of employees are considered to be made at the same time. For example, if salaried employees are paid monthly and hourly employees are paid bi-weekly, an employer may contribute to the HSAs of hourly employees on a bi-weekly basis and to the HSAs of salaried employees on a monthly basis. An employer may change the amount that it contributes to the HSAs of employees at any point. However, the changed contribution amounts must satisfy the comparability rules.

(c) *Examples*. The following examples illustrate the rules in paragraph (b) of this Q & A–2: The examples read as follows:

Example 1. (i) Beginning on January 1st, Employer H contributes $50 per month on the first day of each month to the HSA of each employee who is an eligible individual on that date. Employer H does not contribute to the HSAs of former employees. In mid-March of the same year, Employee X, an eligible individual, terminates employment after Employer H has contributed $150 to X's HSA. After X terminates employment, Employer H does not contribute additional amounts to X's HSA. In mid-April of the same year, Employer H hires Employee Y, an eligible individual, and contributes $50 to Y's HSA in May and $50 in June. Effective in July of the same year, Employer H stops contributing to the HSAs of all employees and makes no contributions to the HSA of any employee for the months of July through December. In August, Employer H hires Employee Z, an eligible individual. Employer H does not contribute to Z's HSA. After Z is hired, Employer H does not hire additional employees. As of the end of the calendar year, Employer H has made the following HSA contributions to its employees' HSAs—

(A) Employer H contributed $150 to X's HSA;

(B) Employer H contributed $100 to Y's HSA;

(C) Employer H did not contribute to Z's HSA; and

(D) Employer H contributed $300 to the HSA of each employee who was an eligible individual and employed by Employer J from January through June.

(ii) Employer H's contributions satisfy the comparability rules.

Example 2. In a calendar year, Employer J offers its employees an HDHP and contributes on a monthly pay-as-you-go basis to the HSAs of employees who are eligible individuals with coverage under Employer J's HDHP. In the calendar year, Employer J contributes $50 per month to the HSA of each employee with self-only HDHP coverage and $100 per month to the HSA of each employee with family HDHP coverage. From January 1st through March 31st of the calendar year, Employee X is an eligible individual with self-only HDHP coverage. From April 1st through December 31st of the calendar year, X is an eligible individual with family HDHP coverage. For the months of January, February and March of the calendar year, Employer J contributes $50 per month to X's HSA. For the remaining months of the calendar year, Employer J contributes $100 per month to X's HSA. Employer J's contributions to X's HSA satisfy the comparibility rules.

(d) *Contributions on a look-back basis*. An employer may also satisfy the comparability rules by determining comparable contributions for the calendar year at the end of the calendar year, taking into account all employees who were eligible individuals for any month during the calendar year and contributing the same percentage of the HDHP deductible or the same dollar amount to the HSAs of all employees with the same category of coverage for that month.

(e) *Examples*. The following examples illustrate the rules in paragraph (d) of this Q & A–2. The examples read as follows:

Example 1. In a calendar year, Employer K offers its employees an HDHP and contributes on a look-back basis to the HSAs of employees who are eligible individuals with

coverage under Employer K's HDHP. Employer K contributes $600 ($50 per month) for the calendar year to the HSA of each employee with self-only HDHP coverage and $1,200 ($100 per month) for the calendar year to the HSA of each employee with family HDHP coverage. From January 1st through June 30th of the calendar year, Employee Y is an eligible individual with family HDHP coverage. From July 1st through December 31st, Y is an eligible individual with self-only HDHP coverage. Employer K contributes $900 on a look-back basis for the calendar year to Y's HSA ($100) per month for the months of January through June and $50 per month for the months of July through December. Employer K's contributions to Y's HSA satisfy the comparability rules.

Example 2. On December 31st, Employer L contributes $50 per month on a look-back basis to each employee's HSA for each month in the calendar year that the employee was an eligible individual. In mid-March of the same year, Employee T, an eligible individual, terminated employment. In mid-April of the same year, Employer L hired Employee U, who becomes an eligible individual as of May 1st and works for Employer L through December 31st. On December 31st, Employer L contributes $150 to Employee T's HSA and $400 to Employee U's HSA. Employer L's contributions satisfy the comparability rules.

(f) *Periods and dates for making contributions*. With both the pay-as-you-go method and the look-back method, an employer may establish, on a reasonable and consistent basis, periods for which contributions will be made (for example, a quarterly period covering three consecutive months in a calendar year) and the dates on which such contributions will be made for that designated period (for example, the first day of the quarter or the last day of the quarter in the case of an employer who has established a quarterly period for making contributions). An employer that makes contributions on a pay-as-you-go basis for a period covering more than one month will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the period for which contributions were made has received more contributions on a monthly basis than employees who have worked the entire period. In addition, an employer that makes contributions on a pay-as-you-go basis for a period covering more than one month must make HSA contributions for any comparable participating employees hired after the date of initial funding for that period.

(g) *Example*. The following example illustrates the rules in paragraph (f) of this Q & A–2:

Example. Employer M has established, on a reasonable and consistent basis, a quarterly period for making contributions to the HSAs of eligible employees on a pay-as-you-go basis. Beginning on January 1st, Employer M contributes $150 for the first three months of the calendar year to the HSA of each employee who is an eligible individual on that date. On January 15th, Employee V, an eligible individual, terminated employment after Employer M has contributed $150 to V's HSA. On January 15th, Employer M hired Employee W, who becomes an eligible individual as of February 1st. On April 1st, Employer M has contributed $100 to W's HSA for the two months (February and March) in the quarter period that Employee W was an eligible employee. Employer M's contributions satisfy the comparability rules.

(h) *Maximum contribution permitted for all employees who are eligible individuals during the last month of the taxable year*. An employer may contribute up to the maximum annual contribution amount for the calendar year (based on the employees' HDHP coverage) to the HSAs of all employees who are eligible individuals on the first day of the last month of the employees' taxable year, including employees who worked for the employer for less than the entire calendar year and employees who became eligible individuals after January 1st of the calendar year. For example, such contribution may be made on behalf of an eligible individual who is hired after January 1st or an employee who becomes an eligible individual after January 1st. Employers are not required to provide more than a pro-rata contribution based on the number of months that an individual was an eligible individual and employed by the employer during the year. However, if an employer contributes more than a pro-rata amount for the calendar year to the HSA of any eligible individual who is hired after January 1st of the calendar year or any employee who becomes an eligible individual any time after January 1st of the calendar year, the employer must contribute that same amount on an equal and uniform basis to the HSAs of all comparable

participating employees (as defined in Q & A–1 in § 54.4980G–1) who are hired or become eligible individuals after January 1st of the calendar year. Likewise, if an employer contributes the maximum annual contribution amount for the calendar year to the HSA of any eligible individual who is hired after January 1st of the calendar year or any employee who becomes an eligible individual any time after January 1st of the calendar year, the employer must contribute the maximum annual contribution amount on an equal and uniform basis to the HSAs of all comparable participating employees (as defined in Q & A–1 in § 54.4980G–1) who are hired or become eligible individuals after January 1st of the calendar year. An employer who makes the maximum calendar year contribution or more than a pro-rata contribution to the HSAs of employees who become eligible individuals after the first day of the calendar year or eligible individuals who are hired after the first day of the calendar year will not fail to satisfy comparability merely because some employees will have received more contributions on a monthly basis than employees who worked the entire calendar year.

(i) *Examples*. The following examples illustrate the rules in paragraph (h) in this Q & A–2. In the following examples, no contributions are made through a section 125 cafeteria plan and none of the employees are covered by a collective bargaining agreement.

Example 1. On January 1, 2010, Employer Q contributes $1,000 for the calendar year to the HSAs of employees who are eligible individuals with family HDHP coverage. In mid-March of the same year, Employer Q hires Employee A, an eligible individual with family HDHP coverage. On April 1, 2010, Employer Q contributes $1,000 to the HSA of Employee A. In September of the same year, Employee B becomes an eligible individual with family HDHP coverage. On October 1, 2010, Employer G contributes $1,000 to the HSA of Employee B. Employer Q does not make any other contributions for the 2010 calendar year. Employer Q's contributions satisfy the comparability rules.

Example 2. For the 2010 calendar year, Employer R only has two employees, Employee C and Employee D. Employee C, an eligible individual with family HDHP coverage, works for Employer R for the entire calendar year. Employee D, an eligible individual with family HDHP coverage works for Employer R from July 1st through December 31st. Employer R contributes $1,200 for the calendar year to the HSA of Employee C and $600 to the HSA of Employee D. Employer R does not make any other contributions for the 2010 calendar year. Employer R's contributions satisfy the comparability rules.

(j) *Effective/applicability date*. The rules in paragraphs (h) and (i) of Q & A–2 are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

Q–3: How do the comparability rules apply to employer contributions to employees' HSAs if some non-collectively bargained employees work full-time during the entire calendar year, and other non-collectively bargained employees work full-time for less than the entire calendar year?

A–3: Employer contributions to the HSAs of employees who work full-time for less than twelve months satisfy the comparability rules if the contribution amount is comparable when determined on a month-to-month basis. For example, if the employer contributes $240 to the HSA of each full-time employee who works the entire calendar year, the employer must contribute $60 to the HSA of each full-time employee who works on the first day of each three months of the calendar year. The rules set forth in this Q & A–2 apply to employer contributions made on a pay-as-you-go basis or on a look-back basis as described in Q & A–3 of this section. See sections 4980G(b) and 4980E(d)(2)(B).

Q–4: May an employer make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year (on a pre-funded basis) instead of contributing on a pay-as-you-go or on a look-back basis?

A–4: (a) *Contributions on a pre-funded basis*. Yes. An employer may make contributions for the entire year to the HSAs of its employees who are eligible individuals at the beginning of the calendar year. An employer that pre-funds the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year.

See Q & A–12 of this section. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable. An employer must make comparable contributions for all employees who are comparable participating employees for any month during the calendar year, including employees who are eligible individuals hired after the date of initial funding. An employer that makes HSA contributions on a pre-funded basis may also contribute on a pre-funded basis to the HSAs of employees who are eligible individuals hired after the date of initial funding. Alternatively, an employer that has pre-funded the HSAs of comparable participating employees may contribute to the HSAs of employees who are eligible individuals hired after the date of initial funding on a pay-as-you-go basis or on a look-back basis. An employer that makes HSA contributions on a pre-funded basis must use the same contribution method for all employees who are eligible individuals hired after the date of initial funding.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–4:

Example. (i) On January 1, Employer N contributes $1,200 for the calendar year on a pre-funded basis to the HSA of each employee who is an eligible individual. In mid-May, Employer N hires Employee B, who becomes an eligible individual as of June 1st. Therefore, Employer N is required to make comparable contributions to B's HSA beginning in June. Employer N satisfies the comparability rules with respect to contributions to B's HSA if it makes HSA contributions in any one of the following ways—

(A) Pre-funding B's HSA by contributing $700 to B's HSA;

(B) Contributing $100 per month on a pay-as-you-go basis to B's HSA; or

(C) Contributing to B's HSA at the end of the calendar year taking into account each month that B was an eligible individual and employed by Employer M.

(ii) If Employer M hires additional employees who are eligible individuals after initial funding, it must use the same contribution method for these employees that it used to contribute to B's HSA.

Q–5: Must an employer use the same contribution method as described in Q & A–2 and Q & A–4 of this section for all employees who were comparable participating employees for any month during the calendar year?

A–5: Yes. If an employer makes comparable HSA contributions on a pay-as-you-go basis, it must do so for each employee who is a comparable participating employee as of the first day of the month. If an employer makes comparable contributions on a look-back basis, it must do so for each employee who was a comparable participating employee for any month during the calendar year. If an employer makes HSA contributions on a pre-funded basis, it must do so for all employees who are comparable participating employees at the beginning of the calendar year and must make comparable HSA contributions for all employees who are comparable participating employees for any month during the calendar year, including employees who are eligible individuals hired after the date of initial funding. See Q & A–4 of this section for rules regarding contributions for employees hired after initial funding.

Q–6: How does an employer comply with the comparability rules if an employee has not established an HSA at the time the employer contributes to its employees' HSAs?

A–6: (a) *Employee has not established an HSA at the time the employer funds its employees' HSAs*. If an employee has not established an HSA at the time the employer funds its employees' HSAs, the employer complies with the comparability rules by contributing comparable amounts plus reasonable interest to the employee's HSA when the employee establishes the HSA, taking into account each month that the employee was a comparable participating employee. See Q & A–13 of this section for rules regarding reasonable interest.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–6:

Example. Beginning on January 1st, Employer O contributes $500 per calendar year on a pay-as-you-go basis to the HSA of each employee who is an eligible individual. Employee C is an eligible individual during the entire calendar year but does not establish an HSA until March. Notwithstanding C's delay in establishing an HSA, Employer O must make up the missed HSA contributions plus reasonable interest for January and

February by April 15th of the following calendar year.

Q–7: If an employer bases its contributions on a percentage of the HDHP deductible, how is the correct percentage or dollar amount computed?

A–7: (a) *Computing HSA contributions.* The correct percentage is determined by rounding to the nearest 1/100th of a percentage point and the dollar amount is determined by rounding to the nearest whole dollar.

(b) *Example.* The following example illustrates the rules in paragraph (a) of this Q & A–7:

Example. In this *Example*, assume that each HDHP provided by Employer P satisfies the definition of an HDHP for the 2007 calendar year. In the 2007 calendar year, Employer P maintains two HDHPs. Plan A has a deductible of $3,000 for self-only coverage. Employer P contributes $1,000 for the calendar year to the HSA of each employee covered under Plan A. Plan B has a deductible of $3,500 for self-only coverage. Employer P satisfies the comparability rules if it makes either of the following contributions for the 2007 calendar year to the HSA of each employee who is an eligible individual with self-only coverage under Plan B—

(i) $1,000; or

(ii) $1,167 (33.33% of the deductible rounded to the nearest whole dollar amount).

Q–8: Does an employer that contributes to the HSA of each comparable participating employee in an amount equal to the employee's HSA contribution or a percentage of the employee's HSA contribution (matching contributions) satisfy the rule that all comparable participating employees receive comparable contributions?

A–8: No. If all comparable participating employees do not contribute the same amount to their HSAs and, consequently, do not receive comparable contributions to their HSAs, the comparability rules are not satisfied, notwithstanding that the employer offers to make available the same contribution amount to each comparable participating employee. But see Q & A–1 in § 54.4980G–5 on contributions to HSAs made through a cafeteria plan.

Q–9: If an employer conditions contributions by the employer to an employee's HSA on an employee's participation in health assessments, disease management programs or wellness programs and makes the same contributions available to all employees who participate in the programs, do the contributions satisfy the comparability rules?

A–9: No. If all comparable participating employees do not elect to participate in all the programs and consequently, all comparable participating employees do not receive comparable contributions to their HSAs, the employer contributions fail to satisfy the comparability rules. But see Q & A–1 in § 54.4980G–5 on contributions made to HSAs through a cafeteria plan.

Q–10: If an employer makes additional contributions to the HSAs of all comparable participating employees who have attained a specified age or who have worked for the employer for a specified number of years, do the contributions satisfy the comparability rules?

A–10: No. If all comparable participating employees do not meet the age or length of service requirement, all comparable participating employees do not receive comparable contributions to their HSAs and the employer contributions fail to satisfy the comparability rules.

Q–11: If an employer makes additional contributions to the HSAs of all comparable participating employees who are eligible to make the additional contributions (HSA catch-up contributions) under section 223(b)(3), do the contributions satisfy the comparability rules?

A–11: No. If all comparable participating employees are not eligible to make the additional HSA contributions under section 223(b)(3), all comparable participating employees do not receive comparable contributions to their HSAs, and the employer contributions fail to satisfy the comparability rules.

Q–12: If an employer's contributions to an employee's HSA result in noncomparable contributions, may the employer recoup the excess amount from the employee's HSA?

A–12: No. An employer may not recoup from an employee's HSA any portion of the employer's contribution to the employee's HSA. Under section 223(d)(1)(E), an account beneficiary's interest in an HSA is nonforfeitable.

However, an employer may make additional HSA contributions to satisfy the comparability rules. An employer may contribute up until April 15th following the calendar year in which the non-comparable contributions were made. An employer that makes additional HSA contributions to correct non-comparable contributions must also contribute reasonable interest. However, an employer is not required to contribute amounts in excess of the annual contribution limits in section 223(b). See Q & A–13 of this section for rules regarding reasonable interest.

Q–13: What constitutes a reasonable interest rate for purposes of making comparable contributions?

A–13: The determination of whether a rate of interest used by an employer is reasonable will be based on all of the facts and circumstances. If an employer calculates interest using the Federal short-term rate as determined by the Secretary in accordance with section 1274(d), the employer is deemed to use a reasonable interest rate.

Q–14: Does an employer fail to satisfy the comparability rules for a calendar year if the employer fails to make contributions with respect to eligible employees because the employee has not established an HSA or because the employer does not know that the employee has established an HSA?

A–14: (a) *In general.* An employer will not fail to satisfy the comparability rules for a calendar year (Year 1) merely because the employer fails to make contributions with respect to an eligible employee because the employee has not established an HSA or because the employer does not know that the employee has established an HSA, if—

(1) The employer provides timely written notice to all such eligible employees that it will make comparable contributions for Year 1 for eligible employees who, by the last day of February of the following calendar year (Year 2), both establish an HSA and notify the employer (in accordance with a procedure specified in the notice) that they have established an HSA; and

(2) For each such eligible employee who establishes an HSA and so notifies the employer on or before the last day of February of Year 2, the employer contributes to the HSA for Year 1 comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest by April 15th of Year 2.

(b) *Notice.* The notice described in paragraph (a) of this Q & A–14 must be provided to each eligible employee who has not established an HSA by December 31 of Year 1 or if the employer does not know if the employee established an HSA. The employer may provide the notice to other employees as well. However, if an employee has earlier notified the employer that he or she has established an HSA, or if the employer has previously made contributions to that employee's HSA, the employer may not condition making comparable contributions on receipt of any additional notice from that employee. For each calendar year, a notice is deemed to be timely if the employer provides the notice no earlier than 90 days before the first HSA employer contribution for that calendar year and no later than January 15 of the following calendar year.

(c) *Model notice.* Employers may use the following sample language as a basis in preparing their own notices.

Notice to Employees Regarding Employer Contributions to HSAs:

This notice explains how you may be eligible to receive contributions from [employer] if you are covered by a High Deductible Health Plan (HDHP). [Employer] provides contributions to the Health Savings Account (HSA) of each employee who is [insert employer's eligibility requirements for HSA contributions] (''eligible employee''). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) Establish an HSA on or before the last day in February of [insert year after the year for which the contribution is being made] and;

(2) Notify [insert name and contact information for appropriate person to be contacted] of your HSA account information on or before the last day in February of [insert year after year for which the contribution is being made]. [Specify the HSA account information that the employee must provide (e.g., account number, name and address of trustee or custodian, etc.) and the method by which the employee must provide this account information (e.g., in writing, by e-mail, on a certain form, etc.)].

If you establish your HSA on or before the last day of February in [insert year after

year for which the contribution is being made] and notify [employer] of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for [insert year for which contribution is being made] by April 15 of [insert year after year for which contribution is being made]. If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for [insert applicable year]. You may notify us that you have established an HSA by sending an [e-mail or] a written notice to [insert name, title and, if applicable, e-mail address]. If you have any questions about this notice, you can contact [insert name and title] at [insert telephone number or other contact information].

(d) [Reserved]

(e) *Electronic delivery*. An employer may furnish the notice required under this section electronically in accordance with § 1.401(a)-21 of this chapter.

(f) *Examples*. The following examples illustrate the rules in this Q & A–14:

Example 1. In a calendar year, Employer Q contributes to the HSAs of current employees who are eligible individuals covered under any HDHP. For the 2009 calendar year, Employer Q contributes $50 per month on the first day of each month, beginning January 1st, to the HSA of each employee who is an eligible employee on that date. For the 2009 calendar year, Employer Q provides written notice satisfying the content requirements of this Q & A–14 on October 16, 2008 to all employees regarding the availability of HSA contributions for eligible employees. For eligible employees who are hired after October 16, 2008, Employer Q provides such a notice no later than January 15, 2010. Employer Q's notice satisfies the notice timing requirements in paragraph (a)(1) of this Q & A–14.

Example 2. Employer R's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer R automatically contributes a non-elective matching contribution to the HSA of each employee who makes a pre-tax HSA contribution. Because Employer R's HSA contributions are made through the cafeteria plan, the comparability requirements do not apply to the HSA contributions made by Employer R. Consequently, Employer R is not required to provide written notice to its employees regarding the availability of this matching HSA contribution. See Q & A–1 in § 54.4980G–5 for treatment of HSA contributions made through a cafeteria plan.

Example 3. In a calendar year, Employer S maintains an HDHP and only contributes to the HSAs of eligible employees who elect coverage under its HDHP. For the 2009 calendar year, Employer S employs ten eligible employees and all ten employees have elected coverage under Employer S's HDHP and have established HSAs. For the 2009 calendar year, Employer S makes comparable contributions to the HSAs of all ten employees. Employer S satisfies the comparability rules. Thus, Employer S is not required to provide written notice to its employees regarding the availability of HSA contributions for eligible employees.

Example 4. In a calendar year, Employer T contributes to the HSAs of current full-time employees with family coverage under any HDHP. For the 2009 calendar year, Employer T provides timely written notice satisfying the content requirements of this section to all employees regardless of HDHP coverage. Employer T makes identical monthly contributions to all eligible employees (meaning full time employees with family HDHP coverage) that establish HSAs. Employer T contributes comparable amounts (taking into account each month that the employee was a comparable participating employee) plus reasonable interest to the HSAs of the eligible employees that establish HSAs and provide the necessary information after the end of the year but on or before the last day of February, 2010. Employer T makes no contribution to the HSAs of employees that do not establish an HSA or that do not provide the necessary information on or before the last day of February, 2010. Employer T satisfies the comparability requirements.

Example 5. For the 2009 calendar year, Employer V contributes to the HSAs of current full time employees with family coverage under any HDHP. Employer V has 500 current full time employees. As of the date for Employer V's first HSA contribution for the 2009 calendar year, 450 eligible employees have established HSAs. Employer V provides timely written notice satisfying the content requirements of this section only to those 50 eligible employees who have not established HSAs. Employer V makes identical quarterly contributions to the 450 eligible employees who established HSAs. By April 15, 2010, Employer V contributes comparable amounts to the other eligible employees who establish HSAs and provide the necessary information on or before the last day of February, 2010. Employer V makes no contribution to the HSAs of eligible employees that do not establish an HSA or that do not provide the necessary information on or before the last day of February, 2010. Employer V satisfies the comparability rules.

Q–15: For any calendar year, may an employer accelerate part or all of its contributions for the entire year to the

HSAs of employees who have incurred, during the calendar year, qualified medical expenses (as defined in section 223(d)(2)) exceeding the employer's cumulative HSA contributions at that time?

A–15: (a) *In general*. Yes. For any calendar year, an employer may accelerate part or all of its contributions for the entire year to the HSAs of employees who have incurred, during the calendar year, qualified medical expenses exceeding the employer's cumulative HSA contributions at that time. If an employer accelerates contributions to the HSA of any such eligible employee, all accelerated contributions must be available throughout the calendar year on an equal and uniform basis to all such eligible employees. Employers must establish reasonable uniform methods and requirements for accelerated contributions and the determination of medical expenses.

(b) *Satisfying comparability*. An employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because employees who incur qualifying medical expenses exceeding the employer's cumulative HSA contributions at that time have received more contributions in a given period than comparable employees who do not incur such expenses, provided that all comparable employees receive the same amount or the same percentage for the calendar year. Also, an employer that accelerates contributions to the HSAs of its employees will not fail to satisfy the comparability rules because an employee who terminates employment prior to the end of the calendar year has received more contributions on a monthly basis than employees who work the entire calendar year. An employer is not required to contribute reasonable interest on either accelerated or non-accelerated HSA contributions. But see Q & A–6 and Q & A–12 of this section for when reasonable interest must be paid.

Q–16: What is the effective date for the rules in Q & A–14 and Q & A–15 of this section?

A–16: These regulations apply to employer contributions made for calendar years beginning on or after January 1, 2009.

[T.D. 9277, 71 FR 43058, July 31, 2006; 71 FR 53967, Sept. 13, 2006, as amended by T.D. 9393, 73 FR 20795, Apr. 17, 2008; T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–5 HSA comparability rules and cafeteria plans and waiver of excise tax.

Q–1: If an employer makes contributions through a section 125 cafeteria plan to the HSA of each employee who is an eligible individual, are the contributions subject to the comparability rules?

A–1: (a) *In general*. No. The comparability rules do not apply to HSA contributions that an employer makes through a section 125 cafeteria plan. However, contributions to an HSA made through a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See section 125(b), (c) and (g) and the regulations thereunder.

(b) *Contributions made through a section 125 cafeteria plan*. Employer contributions to employees' HSAs are made through a section 125 cafeteria plan and are subject to the section 125 cafeteria plan nondiscrimination rules and not the comparability rules if under the written cafeteria plan, the employees have the right to elect to receive cash or other taxable benefits in lieu of all or a portion of an HSA contribution (meaning that all or a portion of the HSA contributions are available as pre-tax salary reduction amounts), regardless of whether an employee actually elects to contribute any amount to the HSA by salary reduction.

Q–2: If an employer makes contributions through a cafeteria plan to the HSA of each employee who is an eligible individual in an amount equal to the amount of the employee's HSA contribution or a percentage of the amount of the employee's HSA contribution (matching contributions), are the contributions subject to the section 4980G comparability rules?

A–2: No. The comparability rules do not apply to HSA contributions that an employer makes through a section 125

cafeteria plan. Thus, where matching contributions are made by an employer through a cafeteria plan, the contributions are not subject to the comparability rules of section 4980G. However, contributions, including matching contributions, to an HSA made under a cafeteria plan are subject to the section 125 nondiscrimination rules (eligibility rules, contributions and benefits tests and key employee concentration tests). See Q & A–1 of this section.

Q–3: If under the employer's cafeteria plan, employees who are eligible individuals and who participate in health assessments, disease management programs or wellness programs receive an employer contribution to an HSA and the employees have the right to elect to make pre-tax salary reduction contributions to their HSAs, are the contributions subject to the comparability rules?

A–3: (a) *In general*. No. The comparability rules do not apply to employer contributions to an HSA made through a cafeteria plan. See Q & A–1 of this section.

(b) *Examples*. The following examples illustrate the rules in this § 54.4980G–5. The examples read as follows:

Example 1. Employer A's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply because the HSA contributions are made through the cafeteria plan.

Example 2. Employer B's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer B automatically contributes a non-elective matching contribution or seed money to the HSA of each employee who makes a pre-tax HSA contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer B's HSA contributions because the HSA contributions are made through the cafeteria plan.

Example 3. Employer C's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employer C makes a non-elective contribution to the HSAs of all employees who complete a health risk assessment and participate in Employer C's wellness program. Employees do not have the right to receive cash or other taxable benefits in lieu of Employer C's non-elective contribution. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer C's HSA contributions because the HSA contributions are made through the cafeteria plan.

Example 4. Employer D's written cafeteria plan permits employees to elect to make pre-tax salary reduction contributions to their HSAs. Employees making this election have the right to receive cash or other taxable benefits in lieu of their HSA pre-tax contribution. Employees participating in the plan who are eligible individuals receive automatic employer contributions to their HSAs. Employees make no election with respect to Employer D's contribution and do not have the right to receive cash or other taxable benefits in lieu of Employer D's contribution but are permitted to make their own pre-tax salary reduction contributions to fund their HSAs. The section 125 cafeteria plan nondiscrimination rules and not the comparability rules apply to Employer D's HSA contributions because the HSA contributions are made through the cafeteria plan.

Q–4: May all or part of the excise tax imposed under section 4980G be waived?

A–4: In the case of a failure which is due to reasonable cause and not to willful neglect, all or a portion of the excise tax imposed under section 4980G may be waived to the extent that the payment of the tax would be excessive relative to the failure involved. See sections 4980G(b) and 4980E(c).

[T.D. 9277, 71 FR 43058, July 31, 2006]

§ 54.4980G–6 Special rule for contributions made to the HSAs of nonhighly compensated employees.

Q–1: May an employer make larger contributions to the HSAs of nonhighly compensated employees than to the HSAs of highly compensated employees?

A–1: Yes. Employers may make larger HSA contributions for nonhighly compensated employees who are comparable participating employees than for highly compensated employees who are comparable participating employees. *See* Q & A–1 in § 54.4980G–1 for the

definition of comparable participating employee. For purposes of this section, highly compensated employee is defined under section 414(q). Nonhighly compensated employees are employees that are not highly compensated employees. The comparability rules continue to apply with respect to contributions to the HSAs of all nonhighly compensated employees. Employers must make comparable contributions for the calendar year to the HSA of each nonhighly compensated employee who is a comparable participating employee.

Q–2: May an employer make larger contributions to the HSAs of highly compensated employees than to the HSAs of nonhighly compensated employees?

A–2: (a) *In general*. No. Employer contributions to HSAs for highly compensated employees who are comparable participating employees may not be larger than employer HSA contributions for nonhighly compensated employees who are comparable participating employees. The comparability rules continue to apply with respect to contributions to the HSAs of all highly compensated employees. Employers must make comparable contributions for the calendar year to the HSA of each highly compensated comparable participating employee. *See* Q & A–1 in § 54.4980G–1 for the definition of comparable participating employee.

(b) *Examples*. The following examples illustrate the rules in Q & A–1 and Q & A–2 of this section. No contributions are made through a section 125 cafeteria plan and none of the employees in the following examples are covered by a collective bargaining agreement. All of the employees in the following examples have the same HDHP deductible for the same category of coverage.

Example 1. In 2010, Employer A contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer A makes no contribution to the HSA of any full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer A's HSA contributions for calendar year 2010 satisfy the comparability rules.

Example 2. In 2010, Employer B contributes $2,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer B also contributes $1,000 for the calendar year to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer B's HSA contributions for calendar year 2010 satisfy the comparability rules.

Example 3. In 2010, Employer C contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer C contributes $2,000 for the calendar year to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. Employer C's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Example 4. In 2010, Employer D contributes $1,000 for the calendar year to the HSA of each full-time nonhighly compensated employee who is an eligible individual with self-only HDHP coverage. Employer D also contributes $1,000 to the HSA of each full-time highly compensated employee who is an eligible individual with self-only HDHP coverage. In addition, the employer contributes an additional $500 to the HSA of each nonhighly compensated employee who participates in a wellness program. The nonhighly compensated employees did not receive comparable contributions, and, therefore, Employer D's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Example 5. In 2010, Employer E contributes $1,000 for the calendar year to the HSA of each full-time non-management nonhighly compensated employee who is an eligible individual with family HDHP coverage. Employer E also contributes $500 for the calendar year to the HSA of each full-time management nonhighly compensated employee who is an eligible individual with family HDHP coverage. The nonhighly compensated employees did not receive comparable contributions, and, therefore, Employer E's HSA contributions for calendar year 2010 do not satisfy the comparability rules.

Q–3: May an employer make larger HSA contributions for employees with self plus two HDHP coverage than employees with self plus one HDHP coverage even if the employees with self plus two are all highly compensated employees and the employees with self plus one are all nonhighly compensated employees?

A–3: (a) Yes. Q & A–1 in § 54.4980G–4 provides that an employer's contribution with respect to the self plus two category of HDHP coverage may not be

less than the contribution with respect to the self plus one category and the contribution with respect to the self plus three or more category may not be less than the contribution with respect to the self plus two category. Therefore, the comparability rules are not violated if an employer makes a larger HSA contribution for the self plus two category of HDHP coverage than to self plus one coverage, even if the employees with self plus two coverage are all highly compensated employees and the employees with self plus one coverage are all nonhighly compensated employees. Likewise, the comparability rules are not violated if an employer makes a larger HSA contribution for the self plus three category of HDHP coverage than to self plus two coverage, even if the employees with self plus three coverage are all highly compensated employees and the employees with self plus two coverage are all nonhighly compensated employees.

(b) *Example*. The following example illustrates the rules in paragraph (a) of this Q & A–3. In the following example, no contributions are made through a section 125 cafeteria plan and none of the employees are covered by a collective bargaining agreement.

Example. In 2010, Employer F contributes $1,000 for the calendar year to the HSA of each full-time employee who is an eligible individual with self plus one HDHP coverage. Employer F contributes $1,500 for the calendar year to the HSA of each employee who is an eligible individual with self plus two HDHP coverage. The deductible for both the self plus one HDHP and the self plus two HDHP is $2,000. Employee A, an eligible individual, is a nonhighly compensated employee with self plus one coverage. Employee B, an eligible individual, is a highly compensated employee with self plus two coverage. For the 2010 calendar year, Employer F contributes $1,000 to Employee A's HSA and $1,500 to Employee B's HSA. Employer F's HSA contributions satisfy the comparability rules.

Q–4:What is the effective date for the rules in this section?

A–4: The rules in this section are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45998, Sept. 8, 2009]

§ 54.4980G–7 Special comparability rules for qualified HSA distributions contributed to HSAs on or after December 20, 2006 and before January 1, 2012.

Q–1 How do the comparability rules of section 4980G apply to qualified HSA distributions under section 106(e)(2)?

A–1:The comparability rules of section 4980G do not apply to amounts contributed to employee HSAs through qualified HSA distributions. However, in order to satisfy the comparability rules, if an employer offers qualified HSA distributions, as defined in section 106(e)(2), to any employee who is an eligible individual covered under any HDHP, the employer must offer qualified HSA distributions to all employees who are eligible individuals covered under any HDHP. However, if an employer offers qualified HSA distributions only to employees who are eligible individuals covered under the employer's HDHP, the employer is not required to offer qualified HSA distributions to employees who are eligible individuals but are not covered under the employer's HDHP.

Q–2: What is the effective date for the rules in this section?

A–2: The rules in this section are effective for are effective for employer contributions made for calendar years beginning on or after January 1, 2010.

[T.D. 9457, 74 FR 45999, Sept. 8, 2009]

§ 54.4981A–1T Tax on excess distributions and excess accumulations (temporary).

The following questions and answers relate to the tax on excess distributions and excess accumulations under section 4981A of the Internal Revenue Code of 1986, as added by section 1133 of the Tax Reform Act of 1986 (Pub. L. 99–514) (TRA '86).

Table of Contents

a. General Provisions and Excess Distributions
b. Special Grandfather Rules
c. Special Rules
d. Excess Accumulations

a. General Provisions and Excess Distributions

a-1: Q. What changes were made by section 1133 of TRA '86 regarding excise

taxes applicable to distributions from qualified employer plans and individual retirement plans?

A. Section 1133 of TRA '86 added section 4981A to the Code. Section 4981A imposes an excise tax of 15 percent on (a) excess distributions, as defined in section 4981A(c)(1) and Q&A a-2 of this section, and (b) excess accumulations, as defined in section 4981A(d)(3) and Q&A d-2 of this section. The excise tax on excess distributions generally applies to excess distributions made after December 31, 1986 (see Q&A c-6 of this section). The excise tax on excess accumulations applies to estates of decedents dying after December 31, 1986 (see Q&A d-11 of this section). Excess distributions are certain distributions from qualified employer plans and individual retirement plans. Excess accumulations are certain amounts held on the date of death of an employee or individual by qualified plans and individual retirement plans.

a-2: Q. How are excess distributions defined?

A. Excess distributions are generally defined as the excess of the aggregate amount of distributions received by or with respect to an individual during a calendar year over the greater of (a) $150,000 (unindexed) or (b) $112,500 (indexed as provided in Q&A a-9 of this section beginning in 1988 for cost-of-living increases). Certain individuals may elect to have the portion of their excess distributions that is subject to tax determined under a ''special grandfather'' rule that is described below (see Q&A b-1 through b-14 of this section).

a-3: Q. Distributions from what plans and arrangements are taken into account in applying section 4981A?

A. (a) *General rule.* Section 4981A applies to distributions under any qualified employer plan or individual retirement plan described in section 4981A(e). For this purpose, a qualified employer plan means any—

(1) Qualified pension, profit-sharing or stock bonus plan described in section 401(a) that includes a trust exempt from tax under section 501(a);

(2) Annuity plan described in section 403(a);

(3) Annuity contract, custodial account, or retirement income account described in section 403(b)(1), 403(b)(7) or 403(b)(9); and

(4) Qualified bond purchase plan described in section 405(a) prior to that section's repeal by section 491(a) of the Tax Reform Act of 1984 (TRA '84).

(b) *Individual retirement plan.* An individual retirement plan is defined in section 7701(a)(37) and means any individual retirement account described in section 408(a) or individual retirement annuity described in section 408(b). Also, an individual retirement plan includes a retirement bond described in section 409(a) prior to that section's repeal by section 491(b) of the Tax Reform Act of 1984 (TRA '84).

(c) *Other distributions.* (1) Distributions under any plan, contract or account that has at any time been treated as a qualified employer plan or individual retirement plan described in paragraph (a) or (b) of this Q&A a–3 will be treated for purposes of section 4981A as distributions from a qualified employer plan or individual retirement plan whether or not such plan, contract, or account satisfies the applicable qualification requirements at the time of the distribution.

(2)(i) For purposes of this paragraph (c), an employer plan will be considered to have been treated as a qualified employer plan if any employer maintaining the plan has at any time filed an income tax return and claimed deductions that would be allowable under section 404 (and that were not disallowed) only if the plan was a qualified employer plan under section 401(a) or 403(a). Similarly, if an income tax return has been filed at any time with respect to the trust (or plan or insurance company), and the income of the trust (insurance company, etc.) is reported (and is not disallowed) based on the trust (or plan) being treated as a qualified employer plan described in section 401(a), or 403 (a) or (b), then the employer plan is considered to have been treated as a qualified employer plan.

(ii) For purposes of this paragraph (c), an individual retirement plan (IRA) will be considered to have been treated as a qualified IRA if any contributions to the IRA were either deducted (or designated as a nondeductible contribution described in section 408(o)) on

a filed individual income tax return or excluded from an individual's gross income on a filed income tax return because such contributions were reported as regular contributions or rollover contributions (such as those described in section 402(a)(5), 403(a)(4), 403(b)(8) or 408(d)(3)) to an IRA described in section 408 (a) or (b) (or section 409 of pre-1984 law). Similar treatment applies to an employer contribution to a simplified employee pension described in section 408(k), if such contribution is deducted on an employer's filed income tax return, including a self-employed individual's return.

a–4: Q. Which distributions with respect to an individual under a qualified employer plan or an individual retirement plan are excluded from consideration for purposes of determining an individual's excess distributions?

A. (a) *Exclusions.* In determining the extent to which an individual has excess distributions for a calendar year, the following distributions are disregarded—

(1) Any distribution received by any person with respect to an individual as a result of the death of that individual.

(2) Any distribution with respect to an individual that is received by an alternate payee under a qualified domestic relations order within the meaning of section 414(p) that is includible in the income of the alternate payee.

(3) Any distribution with respect to an individual that is attributable to the individual's investment in the contract as determined under the rules of section 72(f). This would include, for example, distributions that are excluded from gross income under section 72 because they are treated as a recovery of after-tax employee contributions from a qualified employer plan or nondeductible contributions from an individual retirement plan.

(4) Any portion of a distribution to the extent that it is not included in gross income by reason of a rollover contribution described in section 402(a)(5), 403(a)(4), 403(b)(8), or 408(d)(3).

(5) Any health coverage or any distribution of medical benefits provided under an arrangement described in section 401(h) to the extent that the coverage or distribution is excludible under section 104, 105, or 106.

(b) *Alternate payee.* Any distributions to an alternate payee described in paragraph (a)(2) of this Q&A a–4 must be taken into account by such alternate payee for purposes of calculating the excess distributions received by (or excess accumulations held by) the alternate payee.

a–5: Q. If an annuity contract that represents an irrevocable commitment to provide an employee's benefits under the plan is distributed to an individual, how are the distribution of such annuity contract and distributions of amounts under such a contract taken into account for purposes of calculating excess distributions?

A. Except to the extent that the value of an annuity contract is includible in income in the year the contract is distributed or any subsequent year, the distribution of an annuity contract (including a group annuity contract) in satisfaction of plan liabilities is disregarded for purposes of calculating excess distributions. Any amounts that are actually distributed under the contract to the individual (to the extent not excluded under Q&A a–4 of this section) or are otherwise includible in income with respect to the contract (e.g., by reason of the inclusion in income of the value of the annuity contract in the year of the contract's distribution or any subsequent year) are taken into account for purposes of calculating excess distributions for the calendar year during which such amounts are received or otherwise includible in income. For purposes of this Q&A a–5, the term *plan* means any qualified employer plan or individual retirement plan specified in section 4981A(e) and Q&A a–3 of this section.

a–6: Q. Are minimum distributions required under section 401(a)(9), 408(a)(6), 408(b)(3) or 403(b)(10) taken into account to determine excess distributions?

A. Yes. Distributions received during a calendar year are taken into account in determining an individual's excess distributions for such calendar year even though such distributions are required under section 401(a)(9), 408(a)(6), 408(b)(3) or 403(b)(10). For example, minimum distributions under section 401(a)(9) received during the 1987 calendar year for calendar years 1985 and

1986 will be subject to section 4981A as distributions for 1987.

a–7: Q. Are distributions of excess deferrals permitted under section 402(g)(2), or distributions of excess contributions or excess aggregate contributions permitted under section 401(k) or (m), or distributions of IRA contributions permitted under section 408(d) (4) or (5) taken into account for purposes of calculating excess distributions?

A. No. Distributions of excess deferrals, excess contributions, excess aggregate contributions, distributions of IRA contributions, and income allocable to such contributions or deferrals, that are made in accordance with the provisions of sections 402(g)(2), 401(k)(8), 401(m)(6), or 408(d) (4) or (5) are not taken into account for purposes of calculating excess distributions.

a–8: Q. What distributions from qualified employer plans or individual retirement plans are taken into account in determining an individual's excess distributions?

A. With the exception of distributions noted above in Q&As a–4, a–5, and a–7 of this section, all distributions from qualified employer plans or individual retirement plans must be taken into account in determining an individual's excess distributions for the calendar year in which such distributions are received. In general, all such distributions are taken into account whether or not they are currently includible in income. Thus, for example, net unrealized appreciation in employer securities described in section 402(a) is taken into account in the year distributed. However, health coverage or distributions of medical benefits provided under an arrangement described in section 401(h) that are excludible from income under section 104, 105, or 106 are not subject to section 4981A. In addition, distributions that are excludible from income because they are rolled over to a plan or an individual retirement account are not taken into account. (See Q&A a–4(a) (4) and (5) of this section). Amounts that are includible in income for a calendar year are treated as distributions and, thus, are taken into account even if the amounts are not actually distributed during such year. Thus, deemed distributions to provide insurance coverage includible in income under section 72 (PS–58 amounts), loan amounts treated as deemed distributions under section 72(p), and amounts includible under section 402(b) or section 403(c) by reason of the employer plan or individual retirement plan not being qualified during the year are taken into account.

a–9: Q. Will the dollar threshold amount used to determine an individual's excess distributions be adjusted for inflation in calendar years after 1987?

A. Beginning in 1988, the $112,500 threshold amount is adjusted to reflect post-1986 cost-of-living increases (COLAs) at the same time and in the same manner as the adjustment described in section 415(d). The threshold amount is adjusted even though the distribution is from a defined contribution plan that is subject to a freeze on COLAs because the defined benefit plan limit is below $120,000 (see section 415(c)(1)(A)). However, the $150,000 threshold amount is not adjusted to reflect such increases.

b. Special Grandfather Rule

b–1: Q. How are benefits accrued before TRA '86 treated under the excise tax provisions described in section 4981A?

A. (a) *Grandfather amount.* Certain eligible individuals may elect to use a special grandfather rule that exempts from the excise tax the portion of distributions treated as a recovery of such individual's total benefits accrued on or before August 1, 1986 (grandfather amount). However, distributions that are treated as a recovery of the grandfather amount are taken into account in determining the extent to which other distributions are excess distributions (see Q&A b–4 of this section). Under this special grandfather rule, the grandfather amount equals the value of an individual's total benefits (as described in Q&As b–8 and b–9 of this section) in all qualified employer plans and individual retirement plans on August 1, 1986. An individual's benefits in such plans include amounts determinable on August 1, 1986, that are payable to the individual under a qualified domestic relations order within

the meaning of section 414(p) (QDRO). However, QDRO benefits that, when destributed, are includible in the income of the alternate payee are not included in the employee's grandfathered amount. Further, plan benefits that are attributable to a deceased individual and that are payable to an eligible individual as a beneficiary are generally not included in determining the eligible individual's grandfather amount. Procedures for determining the grandfather amount are described in Q&As b–11 through b–14 of this section.

(b) *Recovery of grandfather amount.* The portion of any distribution made after August 1, 1986, that is treated as a recovery of a grandfather amount depends on which of two grandfather recovery methods the individual elects. The two alternative methods are described in the Q&As b–11 through b–14 of this section. The amount of the distribution for a year that is treated as a recovery of a grandfather amount in a year is applied to reduce the individual's unrecovered grandfather amount for future years (*i.e.*, the individual's accrued benefits as described in Q&As b–8 and b–9 on August 1, 1986, reduced by previous distributions treated as a recovery of a grandfather amount) on a dollar for dollar basis until the individual's unrecovered grandfather amount has been reduced to zero. When the individual's grandfather amount has been reduced to zero, the special grandfather rule ceases to apply and the entire amount of any subsequent excess distributions received is subject to the 15 percent excise tax.

b–2: Q. Who may elect to use the special grandfather rules?

A. Any individual whose accrued benefits as described in Q&As b–8 and b–9 of this section in all qualified plans and individual retirement plans on August 1, 1986 (initial grandfather amount) have a value of at least $562,500 may elect to use the special grandfather rule.

b–3: Q. How does an eligible individual make a valid election to use the special grandfather rule?

A. (a) *Form of election.* An individual who is eligible to use the special grandfather rule must affirmatively elect to use that rule. The election is made on a Form 5329 filed with the individual's income tax return (Form 1040, etc.) for a taxable year beginning after December 31, 1986, and before January 1, 1989 (*i.e.*, the 1987 or 1988 taxable year).

(b) *Information required.* The individual must report the following information on the Form 5329:

(1) The individual's initial grandfather amount.

(2) The grandfather recovery method to be used.

(3) Such other information as is required by the Form 5329.

(c) *Deadline for election.* The deadline for filing such election is the due date, calculated with extensions, for filing the individual's 1988 income tax return. If an individual dies before the expiration of such deadline, an election, or the revocation of a prior election, may be made as part of the final income tax return filed on behalf of such deceased individual by the deceased individual's personal representative. An election or revocation of a prior election may also be filed before the expiration of such deadline with Schedule S (Form 706). See Q&A c–7 of this section.

(d) *Revocation of election.* Elections filed before the deadline may be revoked by filing an amended income tax return for any applicable year. A change in the grandfather recovery method is considered a revocation of a prior election and an amended Form 5329 must be filed for any prior year in which a different grandfather recovery method was used. Thus, a change in the election may require a change in the 1987 tax return. An individual must refile for 1987 based on the new election if additional tax is owed. However, an election (or nonelection) is irrevocable after the filing deadline for the taxable year beginning in 1988 has passed. Thus, an individual who has not made an election by the last day plus extensions for filing the 1988 return may not do so through an amended return.

(e) *Subsequent years.* (1) Any eligible individual who has elected the special grandfather rule must attach to the individual's income tax return for all subsequent taxable years in which the individual receives excess distributions (determined without regard to the grandfather rule) a copy of the Form 5329 on which the individual elected the

grandfather rule. A copy of the Form 5329 on which the individual (or the individual's personal representative) elected the grandfather rule must also be filed with Schedule S (Form 706) unless the initial election is filed with such schedule.

(2) The individual must also make such other reports in the form and at the time as the Commissioner may prescribe. See Q&A c–7 of this section for the applicable reporting requirements if the individual or the individual's estate is liable for any tax on excess distributions or on an excess accumulation under section 4981A (a) or (d).

b–4: Q. How individuals who have elected to use the special grandfather rule determine the extent to which their distributions for any calendar year are excess distributions?

A. (a) *Excess distributions under grandfather rule, threshold amount.* Individuals who elect to use the special grandfather rule are not eligible to use the $150,000 threshold amount in computing their excess distributions for any calendar year. Instead, such electing individuals must compute their excess distributions for a calendar year using a $112,500 (indexed for cost-of-living increases) threshold amount. The rule of this paragraph (a) applies for all calendar years, including the calendar year in which an individual's unrecovered grandfather amount has been reduced to zero and all subsequent calendar years. Once the indexed amount has increased to $150,000 or more, the threshold amount will be the same for all individuals.

(b) *Base for excise tax under grandfather rule.* Although the portion of any distribution that is treated as a recovery of an individual's grandfather amount is not subject to the excise tax, such portion must be taken into account in determining the extent to which the individual has excess distributions for a calendar year. The effect of this rule is that the amount against which the 15 percent excise tax is applied for any calendar year during which a grandfather amount is recovered equals the individual's distributions for such year reduced by the greater of (1) the applicable threshold amount for such year or (2) the grandfather amount recovered for such year. (See the examples in Q&A b–14 of this section.)

b–5: Q. How is the value of an individual's total accrued benefits on August 1, 1986, calculated for purposes of determining (a) whether an individual is eligible to elect the special grandfather rule and (b) the amount of any electing individual's initial grandfather amount under such rule?

A. (a) *Introduction.* The value of an individual's total accrued benefits on August 1, 1986, is the sum of the values of the individual's accrued benefits on such date under all qualified employer plans or individual retirement plans, as determined under the Q&A b–5. If such value exceeds $562,500, the individual may elect the special grandfather rule. In such case, the value so determined may be applied against distributions as determined under this section, whether or not such distributions are from the same plan or IRA for which such grandfather amount is determined. For purposes of determining the value of accrued benefits on August 1, 1986, an annuity contract or an individual's interest in a group annuity contract described in Q&A a–5 of this section is treated as an accrued benefit under the qualified retirement plan or IRA from which it was distributed and an IRA is treated as a defined contribution plan.

(b) *Defined benefit plan*—(1) *General rule.* The amount of an individual's accrued benefit on August 1, 1986, under a defined benefit plan is determined as of that date under the provisions of the plan based on the individual's service and compensation on that date. The present value of such benefit is determined by an actuarial valuation of such accrued benefit performed as of August 1, 1986. Alternatively, accrued benefits may be determined as of July 31, 1986. In such case, the applicable rules are applied by substituting the July 31 date for the August 1 date in the applicable provisions. (See Q&A b–9 of this section for rules for determining the amount of benefits and values and the actuarial assumptions to be used in such determination.)

(2) *Alternative method.* Alternatively, the present value of an individual's accrued benefit on August 1, 1986, may be determined using the following method:

(i) Determine the amount of the individual's actual accrued benefit (prior benefit) on the valuation date that immediately precedes August 1, 1986 (prior date). The valuation date for purposes of using this alternative method is the valuation date used for purposes of section 412. In making this determination, plan amendments that are adopted after that prior date are disregarded.

(ii) Determine the amount of the individual's adjusted accrued benefit (adjusted prior benefit) on the prior date by reducing the prior benefit in paragraph (b)(2)(i) of this Q&A b–5 by the amount of distributions that reduce the accrued benefit or transfers from the plan and by increasing the prior benefit in paragraph (b)(2)(i) of this Q&A b–5 by any increase in benefit resulting from either transfers to the plan or plan amendments that were made (or, in the case of a plan amendment, both adopted and effective) after the prior valuation date, but on or before August 1, 1986.

(iii) Determine the amount of the individual's actual accrued benefit (future benefit) on the valuation date immediately following August 1, 1986 (next date). In making this determination, plan amendments, etc. that are either adopted or effective after August 1 are disregarded.

(iv) Determine the amount of the individual's adjusted accrued benefit (adjusted future benefit) on the next date by increasing the future benefit in paragraph (b)(2)(iii) of this Q&A b–5 by the amount of any distributions that reduce the accrued benefit or transfers from the plan and by reducing the future benefit in paragraph (b)(2)(iii) of this Q&A b–5 by the amount of any transfer to the plan that was made after August 1, 1986, but on or before the next valuation date to the amount in paragraph (b)(2)(iii) of this Q&A b–5.

(v) Calculate the weighted average of paragraphs (b)(2)(ii) and (b)(2)(iv) of this Q&A b–5, where the weights applied are the number of complete calendar months separating the applicable prior date and the applicable next date, respectively, and August 1, 1986.

(vi) Determine the actuarial present value of the benefit in paragraph (b)(2)(v) of this Q&A b–5 as of August 1, 1986, using the methods and assumptions described in Q&A b–9 of this section.

The grandfather amount on August 1, 1986, attributable to the accrued benefits under the defined benefit plan is equal to the amount determined in paragraph (b)(2)(vi) of this Q&A b–5.

(3) *Certain insurance plans treated as defined contribution plans.* (i) Accrued benefits not in pay status under a plan satisfying the requirements of section 411(b)(1)(F) are determined under the rules in paragraph (c) of this Q&A b–5 for defined contribution plans. For purposes of applying paragraph (c) of this Q&A b–5 to such benefits, the cash surrender value of the contract is substituted for the account balance. If accrued benefits are in pay status under such a plan, the rules of this paragraph (b) apply to such benefits.

(ii) Accrued benefits not in pay status that are attributable to voluntary employee contributions (including rollover amounts) to a defined benefit plan are determined under the rules in paragraph (c) of this Q&A b–5 as if the account balance attributable thereto is under a defined contribution plan. If such benefits are in pay status and are used to fund the benefit under the defined plan, the rules of this paragraph (b) apply to such benefits.

(c) *Defined contribution plan*—(1) *General rule.* The value of an individual's accrued benefit on August 1, 1986, under a defined contribution plan (including IRAs) is the value of the individual's account balance on such date (or on the immediately preceding day). Paragraph (b)(3) of this Q&A b–5 requires that benefits derived from certain insured plans and from voluntary contributions to a defined benefit plan be determined under the rules of this paragraph (c).

(2) *Alternative method.* Alternatively, if a valuation was not performed as of August 1, 1986 (or as of the immediately preceding day), the value of an individual's accrued benefit may be determined as follows:

(i) Determine the value of the individual's account balance on the valuation date immediately preceding August 1, 1986 (prior valuation date).

(ii) Determine the value of the individual's adjusted account balance on

the prior valuation date by subtracting (or adding, respectively) the amount of any distribution, including a transfer to another plan or a forfeiture from the account balance (or the amount of any allocation to the account balance, including a transfer from another plan, rollover received or forfeiture from another account) that was made after the prior valuation date but on or before August 1, 1986, from (or to) the amount in paragraph (c)(2)(i) of this Q&A b–5.

(iii) Determine the value of the individual's account balance on the valuation date immediately following August 1, 1986 (next valuation date).

(iv) Determine the value of the individual's adjusted account balance on the next valuation date by adding (or subtracting, respectively) the amount of any distribution, of a type described in paragraph (c)(2)(ii) of this Q&A b–5 (or the amount of any allocation to the account balance, of a type described in paragraph (c)(2)(ii) of this Q&A b–5), that was made after August 1, 1986, but on or before the next valuation date to (or from) the amount in paragraph (c)(2)(iii) of this Q&A b–5.

(v) Calculate the weighted average of paragraphs (c)(2)(ii) and (c)(2)(iv) of this Q&A b–5, where the weights applied are the number of complete calendar months separating the applicable valuation date and the applicable next date, respectively, and August 1, 1986.

The grandfather amount on August 1, 1986, attributable to the account balance in the defined contribution plan or the individual retirement plan is the amount in paragraph (c)(2)(v) of this Q&A b–5.

b–6: Q. For purposes of determining the value of accrued benefits in a defined contribution plan or a defined benefit plan on August 1, 1986, are nonvested benefits taken into account?

A. Yes. All accrued benefits, whether or not vested, are taken into account.

b–7: Q. To what extent are benefits payable with respect to an individual under a qualified employer plan or an individual retirement plan not taken into account for purposes of calculating the individual's grandfather amount?

A. (a) *Exclusions.* The following benefits payable with respect to an individual are not taken into account for purposes of this calculation:

(1) Benefits attributable to investment in the contract as defined in section 72(f). However, amounts attributable to deductible employee contributions (as defined in section 72(o)(5)(A)) are considered part of the accrued benefit.

(2) Amounts that are determinable on August 1, 1986, as payable to an alternate payee who is required to include such amounts in gross income (a spouse or former spouse) under a qualified domestic relations order (QDRO) within the meaning of section 414(p).

(3) Amounts that are attributable to IRA contributions that are distributed pursuant to section 408(d) (4) or (5).

(b) *Alternate payee.* Under a QDRO described in paragraph (a)(2) of this Q&A b–7, amounts are considered part of the accrued benefit of the alternate payee for purposes of calculating the value of the alternate payee's accrued benefit on August 1, 1986. Similarly, such amounts are used by the alternate payee to compute excess distributions.

b–8: Q. What adjustments to the grandfather amount are necessary to take into account rollovers from one qualified employer plan or individual retirement plan to another such plan?

A. (a) *Rollovers outstanding on valuation date.* Generally, rollovers between plans result in adjustment to the grandfather amounts under the rules in Q&A b–5 of this section. However, if a rollover amount is distributed from one plan on or before an applicable valuation date of such plan and is rolled over into the receiving plan after the receiving plan's applicable valuation date and if these events result in an inappropriate duplication or omission of the rollover amount, then an adjustment to the grandfather amount must be made to remove the duplication or omission. The Commissioner may provide necessary rules concerning this adjustment.

(b) *Valuation.* If the rollover amount described in paragraph (a) of this Q&A b–8 is in a form of property other than cash, the property of which the outstanding rollover consists is valued as of the date the rollover contribution is received by the transferee qualified employer plan or individual retirement

plan and that value is the amount of the rollover. If the outstanding rollover is in the form of cash, the amount of the cash is the amount of the rollover.

b–9: Q. What is the form of the grandfather benefit under a defined benefit plan and how is it valued?

A. (a) *Benefit form.* The grandfather amount under a defined benefit plan is determined on the basis of the form of benefit (including any subsidized form of benefit such as a subsidized early retirement benefit or a subsidized joint and survivor annuity) provided under the plan as of August 1, 1986 that has the greatest present value as determined in paragraph (b) of this b–9. If the plan provides a subsidized joint and survivor annuity, for purposes of determining the grandfather amount, it will be assumed that an unmarried individual is married and that the individual spouse is the same age as the individual. Assumptions as to future withdrawals, future salary increases or future cost-of-living increases are not permitted.

(b) *Value of grandfather amount.* The grandfather amount under a defined benefit plan is the present value of the individual's benefit form determined under paragraph (a) of this Q&A b–9. Thus, the benefit form is reduced to reflect its value on the applicable valuation date. The present value of the benefit form on August 1, 1986, or the applicable date, is computed using the factors specified under the terms of the plan as in effect on August 1, 1986, to calculate a single sum distribution if the plan provides for such a distribution. If the plan does not provide for such a distribution form, such present value is computed using the interest rate and mortality assumptions specified in § 20.2031–7 of the Estate Tax Regulations.

b–10: Q. Is the plan administrator (or trustee) of a qualified plan (or individual retirement account) required to report to an individual the value of the individual's benefit under the plan as of August 1, 1986?

A. (a) *Request required.* No report is required unless the individual requests a report and the request is received before April 15, 1989. If requested, the plan administrator (or trustee or issuer) must report to such individual the value of the individual's benefit under the plan as of August 1, 1986, determined in accordance with Q&A b–5 through b–9 of this section. Such report must be made within a reasonable time after the individual's request but not later than July 15, 1989.

(b) *Other rules.* Alternate payees must make their own request for valuation reports. Any report furnished to an employee who has an alternate payee with respect to the plan must include the separate values attributable to each such individual. Any report furnished to an alternate payee must include only the value attributable to the alternate payee. Reports may be furnished to individuals even if no request is made. Individuals must keep records of the reports received from plans or IRAs in order to substantiate all grandfather amounts.

(c) *Authority.* The rules in this Q&A are provided under the authority in section 6047(d).

b–11: Q. How is the portion of a distribution that is treated as a recovery of an individual's grandfather amount as described in b–1 of this section to be calculated?

A. (a) *General rule.* All distributions received between August 1 and December 31, 1986, inclusive, are treated as a recovery of a grandfather amount. The portion of distributions received after December 31, 1986, that is treated as a recovery of the grandfather amount is determined under either the discretionary method or the attained age method. An amount that is treated as a recovery of grandfather benefits is applied to reduce the initial grandfather amount that was calculated as of August 1, 1986, on a dollar for dollar basis until the unrecovered amount has been reduced to zero. No other recalculation of the grandfather amount is to be made for a date after August 1, 1986.

(b) *Methods, etc.* The grandfather amount may be recovered by an individual under either the discretionary method or the attained age method. After the individual's total grandfather amount is treated as recovered under either method, the tax on excess distributions and excess accumulations is determined without regard to any grandfather amount.

b–12: Q. Under the discretionary method, what portion of each distribution is treated as a return of the individual's grandfather amount?

A. (a) *Initial percentage.* Under the discretionary method, unless the individual elects in accordance with paragraph (b) below, 10 percent of the total distributions that the individual receives during any calendar year is treated as a recovery of the grandfather amount.

(b) *Acceleration.* The individual may elect to accelerate the rate of recovery to 100 percent of the total aggregate distributions received during a calendar year commencing with any calendar year, including 1987 (acceleration election). In such case, the rate of recovery is accelerated to 100 percent for the calendar year with respect to which the election is made and for all subsequent calendar years.

(c) *Election.* To recover the grandfather amount using the discretionary method, an individual must elect to use such method when making the election to use the special grandfather rule on the Form 5329. (See Q&A b–3 of this section.) The acceleration election must be made for the individual's taxable year beginning with or within the first calendar year for which such election is made and must be filed with the individual's income tax return for that year. Such acceleration election may also be made or revoked retroactively on an amended return for such year. However, the acceleration election may not be made after the individual's death other than with the individual's final income tax return or with a return for a prior year for which a return was not filed before the individual's death. Thus, the acceleration election may not be made on an amended return filed after the individual's death for a year for which a return was filed before the individual's death. The preceding two sentences shall not apply to deaths occurring in 1987 or 1988. The estate is entitled to use the remaining grandfather amount to determine if there is an excess accumulation. See Q&A d–3 of this section. The acceleration election shall be made on such form and in such manner as the Commissioner prescribes in a manner consistent with the rules of this section.

b–13: Q. Under the attained age method, what portion of each distribution is treated as a return of the individual's grandfather amount?

A. Under the attained age method, the portion of total distributions received during any year that is treated as a recovery of an individual's grandfather amount is calculated by multiplying the individual's aggregate distributions for a calendar year by a fraction. The numerator of the fraction is the difference between the individual's attained age in completed months on August 1, 1986, and the individual's attained age in months at age 35 (420 months). The denominator of the fraction is the difference between the individual's attained age in completed months on December 31 of the calendar year and the individual's attained age in months at age 35 (420 months). An individual whose 35th birthday is after August 1, 1986, may not use the attained age method.

b–14: Q. How is the 15 percent tax with respect to excess distributions for a calendar year calculated by an individual who has elected to use the special grandfather rule?

A. The calculation of the excise tax may be illustrated by the following examples:

Example 1. (a) An individual (A) who participates in two retirement plans, a qualified defined contribution plan and a qualified defined benefit plan, has a total value of accrued benefits on August 1, 1986 under both plans of $1,000,000. Because this amount exceeds $562,500, A is eligible to elect to use the special grandfather rule to calculate the portion of subsequent distributions that are exempt from tax. A elects to use the discretionary grandfather recovery method and attaches a valid election to the 1987 income tax return. A does not elect to accelerate the rate of recovery for 1987. On October 1, 1986, A receives a distribution of $200,000. On February 1, 1987, A receives a distribution of $45,000 and, on November 1, 1987, receives a distribution of $200,000. The 15 percent excise tax applicable to aggregate distributions in 1987 is calculated as follows:

(1) Value of grandfather amount on 8/1/86 ..... $1,000,000
(2) Grandfather amounts recovered in 1986 but after 8/1/86 ..... $200,000
(3) Value of grandfather amount on 12/31/86 ((1) − (2)) $800,000
(4) Grandfather recovery percentage 10%
(5) Distributions between 1/1/87 and 12/

31/87 ($45,000×$200,000) $245,000
(6) Portion of (5) exempt from tax ((4)×(5)) $24,500
(7) Amount potentially subject to tax ((5) − (6)) $220,500
(8) Portion of aggregate distributions in excess of $112,500 ($45,000×$200,000 − $112,500) $132,500
(9) Amount subject to tax (lesser of (7) and (8)) $132,500
(10) Amount of tax (15% of (9)) $19,875
(11) Remaining undistributed value of grandfather amount as of 12/31/87 ((3) − (6)) $775,500

(b) In 1988, A receives no distributions from either plan. On February 1, 1989, A receives a distribution of $300,000 and on December 31, 1989, receives a distribution of $75,000. A makes a valid acceleration election for the 1989 taxable year, whereby A accelerates the rate of grandfather recovery that will apply for calendar years after 1988 to 100 percent. Assume the annual threshold amount for the 1989 calendar year is $125,000 (*i.e.*, 112,500 indexed). The 15 percent excess tax applicable to distributions in 1989 is calculated as follows:

(1) Value of grandfather amount on 8/1/86 ..... $775,500
(2) Grandfather recovery percentage designated for 1989 calendar year 100%
(3) Distributions between 1/1/89 and 12/31/89 ($300,000×$75,000) $375,000
(4) Portion of (3) exempt from tax (2)x(3) $375,000
(5) Amount potentially subject to tax ((3) − (4)) $0
(6) Portion of aggregate distributions in excess of $125,000 ($300,000×$75,000 − $125,000) $250,000
(7) Amount subject to tax (lesser of (5) and (6)) $0
(8) Amount of tax (15% of (7)) $0
(9) Remaining undistributed value of grandfather amount as of 12/31/89 ((1) − (4)) $400,500

The entire amount of any distribution for subsequent calendar years will be treated as a recovery of the grandfather amount and applied against the grandfather amount until the unrecovered grandfather amount is reduced to zero.

Example 2. The facts are the same as in *Example 1* except that A elects to use the attained age recovery method and A makes a valid election for the 1987 taxable year. Further assume that A's attained age in months on August 1, 1986 is 471 months and on December 31, 1987, is 488 months. The 15 percent excise tax applicable to aggregate distributions in 1987 is calculated as follows:

(1) Value of grandfather amount on 8/1/86 ..... $1,000,000
(2) Grandfather amounts recovered in 1986 but after 8/1/86 ..... $200,000
(3) Value of grandfather amount on 12/31/86 ((1) − (2)) $800,000
(4) Completed months of age in excess of 420 on 8/1/86 51
(5) Completed months of age in excess of 420 on 12/31/87 68
(6) Grandfather fraction as of 12/31/86 ((4) divided by (5)) ..... ¾
(7) Distributions between 1/1/87 and 12/31/87 ($45,000 + $200,000) $245,000
(8) Portion of (7) exempt from tax ((6)×(7)) $183,750
(9) Amount potentially subject to tax ((7) − (8)) $61,250
(10) Portion of aggregate distributions in excess of $112,500 ($45,000 + $200,000 − $112,500) $132,500
(11) Amount subject to tax (lesser of (9) and (10)) $61,250
(12) Amount of tax (15% of (11) $9,187
(13) Unrecovered grandfather amount as of 12/31/87 ((3) − (8)) $616,250

c. Special Rules

c-1: Q. How is the excise tax computed if a person elects special tax treatment under section 402 or 403 for a lump sum distribution?

A. (a) *General rule*—(1) *Conditions.* Section 4981A(c)(4) provides for a special tax computation that applies to an individual in a calendar year if the individual receives distributions that include a lump sum distribution and the individual makes certain elections under section 402 or 403 with respect to that lump sum distribution (lump sum election).

(2) *Lump sum election.* A lump sum election includes an election of (i) 5-year income averaging under section 402(e)(4)(B); (ii) phaseout capital gains treatment under sections 402(a)(2) or 403(a)(2) prior to their repeal by section 1122(b) of TRA '86 and as permitted under section 1122(h)(4) of TRA '86; (iii) grandfathered long-term capital gains under sections 402(a)(2) and 403(a) prior to such repeal and as permitted by section 1122(h)(3) of TRA '86; and (iv) grandfathered 10-year income averaging under section 402(e) (including such treatment under a section 402(e)(4)(L) election) prior to amendment by section 1122(a) of TRA '86 and as permitted by section 1122(h)(3)(A)(ii) and (5) of the TRA '86.

(3) *Special tax computation.* (i) If the conditions in paragraph (a)(1) of this Q&A c-1 are satisfied for a calendar year, the rules of this subparagraph

(a)(3) apply for purposes of determining whether there are excess distributions and tax under section 4981A.

(ii) All distributions are divided into two categories. These two categories are the lump sum distribution and other distributions. Whether or not a particular distribution is a distribution subject to section 4981A and is in either category is determined under the rules in section 4981A and this section. Thus, the exclusions under section 4981A(c)(2) and Q&A a-4(a) of this section apply here. For example, a distribution that is a tax-free recovery of employee contributions is not in either category.

(iii) The excise tax under section 4981A(c)(1) is computed in the normal manner except that (A) it is the sum of the otherwise applicable taxes determined separately for the two categories of excess distributions and (B) a different amount (threshold amount) is subtracted from the distributions in each category in determining the amount of the excess distributions. The threshold amount that is subtracted from the portion of the distributions that is not part of the lump sum distribution is the applicable threshold amount, determined without regard to section 4981A(c)(4) and the lump sum election. Thus, the threshold amount subtracted from the amount in this category is either the $150,000 amount or the $112,500 amount (indexed). The threshold amount that is subtracted from the amount of the lump sum distribution is 5 times the applicable threshold amount as described above. Thus, the threshold amount subtracted from the lump sum distribution is $750,000 or 5 times $112,500 indexed (initially $562,500).

(b) *Grandfather rule*—(1) *In general.* This paragraph (b) provides special rules where an individual makes both the grandfather election described in section 4981A(c)(5) and the lump sum election described in paragraph (a) of this Q&A c-1. See Q&A b-11 through 14 for other rules that apply to such grandfather election.

(2) *Discretionary method.* If the individual uses the discretionary method, described in Q&As b-11 and 12 of this section, the applicable threshold amount is $112,500 (indexed). Under this method, the grandfather amount is recovered at a 10 percent or 100 percent rate in any calendar year and is offset separately against distributions in each category of distributions at the appropriate rate. If, for any calendar year, distributions are received in both categories and the total of the appropriate percentage (10 percent or 100 percent) of the distributions in each category exceed the unrecovered grandfathered account, then such grandfather amount must be recovered ratably from the distributions in each category. This rule applies even if the distributions in one category are less than the threshold amount for that category and the distributions in the other category exceed the threshold amount for that category.

(3) *Attained age method.* If the individual uses the attained age method, described in Q&As b-11 and 13 of this section, the threshold amount is $112,500 (indexed). Under this method, to determine the portion of the distributions in each category that is treated as a recovery of the grandfather amount, the fraction described in Q&A b-13 of this section is applied separately to the distributions in each category of distributions. If, for any calendar year, distributions are received in both categories and the total of the amounts of the distributions in each category that are treated as a recovery of the grandfather amount exceeds that undercovered grandfather amount, then such grandfather amount must be recovered ratably from the distributions in each category. This rule applies even if the distributions in one category are less than the threshold amount for that category and the distributions in the other category exceed the threshold amount for that category.

(c) *Amount in lump sum category.* All amounts received from the employer that are required to be distributed to the individual in order to make a lump sum election described in paragraph (a) of this Q&A c-1 are included in the lump sum category. Amounts are in the lump sum category even though they are not subject to income tax under the election. Thus, for example, the following amounts would be in the lump sum category: (1) Appreciation on employer securities received as part of

a distribution for which a lump sum treatment is elected; and (2) amounts that are phased out when section 1122 of TRA '86 is elected. However, accumulated deductible employee contributions under the plan (within the meaning of section 72(o)(5)) are in the nonlump sum category.

(d) *Examples*. The rules in this Q&A c–1 are illustrated by the following examples:

Example 1. (a) On January 1, 199X, individual A who is age 65 and is a calendar year taxpayer receives a lump sum distribution described in section 402(e)(4)(A) from a qualified employer plan (Plan X). A receives no other distribution in 199X. A elects 5-year income averaging under section 402(e)(4)(B) and also elects section 402(e)(4)(L) treatment (treating pre-74 participation as post-1973 participation) on A's income tax return for 199X. Thus, A also makes the lump sum election described in paragraph (a)(2), above. For 199X, the $112,500 threshold amount indexed is $125,000. A does not make a grandfather election so that A's threshold amount is $150,000.

(b) A's distribution from Plan X consists of cash in the amount of $800,000. A has a section 72(f) investment in the contract. A has over the years made after tax contributions to Plan X of $50,000. A's distributions subject to section 4981A equal $750,000 because of the exclusion of A's $50,000 after-tax contributions.

(c) A's distributions consist solely of amounts in the lump sum category. A's threshold amount equals $750,000 under the rules of this paragraph (a)(iii), above, (5 times $150,000). Because A's threshold amount ($750,000) equals the amount of A's distribution from Plan X ($750,000) no part of A's distribution from Plan X is treated as an excess distribution subject to the 15-percent excise tax.

Example 2. (a) Assume the same facts as in *Example (1),* except that A receives an additional distribution from an individual retirement plan described in section 408(a) (IRA Y) in 199X of $150,000. A has made no nondeductible contributions to IRA Y and all of the $150,000 is a distribution subject to section 4981A.

(b) A's distributions consist of two categories, the lump sum category (Plan X $750,000) and the other than lump sum category (IRA Y $150,000). A separate threshold amount is subtracted from A's IRA Y distribution. This threshold amount equals $150,000 under the rules of this paragraph (a)(3), above, the same initial threshold amount that is applied against the lump sum prior to the multiplication by 5). Because A's threshold amount ($150,000) equals the amount of A's distribution from IRA Y ($150,000), no part of A's distribution from IRA Y would be treated as an excess distribution subject to the 15-percent excise tax.

Example 3. (a) Assume the same facts as in *Example (2),* except that A's distribution is $825,000 from Plan X, before reduction of $50,000 for employee contributions, instead of $800,000, so that A's distribution subject to section 4981A from Plan X is $775,000. A made a valid grandfather election. Therefore, the applicable threshold amount is $125,000 ($112,500 indexed for 199X). A's unrecovered grandfather amount as of the end of the year preceding 199X is $1,000,000 (A had a benefit under another retirement plan (Plan Z) on August 1, 1986, and A's account balance under Plan Z, which is a stock bonus plan, is $6,000,000 on January 1, 199X.) A also made a valid election of the discretionary method to recover A's grandfather amount.

(b) If A recovers A's grandfather amount in 199X at the 10 percent rate, 10 percent of A's distributions that are in the lump sum category (Plan X $775,000) is treated as a recovery of A's grandfather amount. Similarly, 10 percent of A's distributions that are in the other than lump sum category (IRA Y $150,000) is treated as a recovery of A's grandfather amount. Thus, A's grandfather amount is reduced by $92,500 ($77,500 Plan X and $15,000 IRA Y) for the 199X calendar year and is $907,500 on January 1 of the year following 199X. Because the amounts of the distributions in each category that are treated as a recovery of grandfather amount are less than the applicable threshold amount for each category ($625,000 Plan X, $125,000 IRA Y), the recovery of the grandfather amount does not affect the calculations of the 199X excise tax.

(c) Because A's distribution from IRA Y of $150,000 exceeds A's threshold amount of $125,000 ($112,500 indexed) applicable to nonlump sum distributions by $25,000 and A's distribution subject to section 4981A from Plan X of $775,000 exceeds A's threshold amount of $625,000 (5X$125,000) applicable to lump sums by $150,000, A is subject to the 15-percent excise tax. A's tax under section 4981A is $26,250 (15 percent of $25,000 plus 15 percent of $150,000).

Example 4. (a) Assume the same facts as in *Example (3)* except that A makes a valid acceleration election under the discretionary method with respect to A's grandfather amount of $1,000,000 for calendar year 199X.

(b) Because A's grandfather amount on January 1, 199X ($1,000,000) equals or exceeds A's distribution subject to section 4981A ($925,000) for 199X, no part of A's distribution from Plan X or IRA Y would be treated as excess distribution subject to the 15-percent excise tax.

(c) A's distributions subject to 4981A from Plan X of $775,000 and from IRA Y of $150,000 are offset 100 percent by A's grandfather

amount of $1,000,000. Therefore, A's grandfather amount on January 1 of the year following 199X is $75,000 ($1,000,000 minus $925,000). This $75,000 would be required to be offset 100 percent against any distributions received in that year.

Example 5. (a) Assume the same facts as in *Example (4),* except that A's distribution subject to section 4981A from Plan X, after reduction of the $50,000 for employee contributions, is $1,000,000 and from IRA Y is $125,000 (equal to the threshold amount), totaling $1,125,000.

(b) Because the sum of the amount received in the lump sum category and the other than lump sum category of distributions is greater than the grandfather amount ($1,000,000), the grandfather amount must be allocated to each separate category on the basis of the ratio of the amount received in each category to the sum of these amounts. Thus, $888,889 ($1,000,000 X ($1,000,000 divided by $1,125,000)) is allocated to the lump-sum category and $111,111 ($1,000,000 X ($125,000 divided by $1,125,000)) is allocated to the other than lump sum category. A's distributions of $1,000,000 in the lump sum category are reduced by $888,889, the greater of $625,000 (the threshold amount) or $888,889 (grandfather amount), and equal $111,111. A's excise tax is $16,666 (15 percent of $111,111). A owes no excess distribution tax on the $125,000 received from IRA Y because it is fully offset by the threshold amount of $125,000.

(c) Because A's distribution subject to section 4981A for the year of $1,125,000 ($1,000,000 plus $125,000) exceeds A's grandfather amount on January 1, 199X of $1,000,000, A's grandfather amount is zero for all subsequent calendar years.

c–2: Q. Must retirement plans be amended to limit future benefits accruals so that the amounts that are distributed would not be subject to an excise tax under section 4981A?

A. No. A qualified employer plan need not be amended to reduce future benefits so that the amount of annual aggregate distributions are not subject to tax under section 4981A. Section 415 does, however, require plan provisions that limit the accrual of benefits and contributions to specified amounts. The operation of the excise tax of section 4981A is independent of plan qualification requirements limiting benefits and contributions under qualified plans.

c–3: Q. Is a plan amendment reducing accrued benefits a permitted method of avoiding the excise tax?

A. No. Accrued benefits may not be reduced to avoid the imposition of the excise tax. Such reduction would violate employer plan qualification requirements, including section 411(d)(6).

c–4: Q. To what extent is the 15 percent section 4981A tax reduced by the 10 percent section 72(t) tax?

A. (a) *General rule.* The 15 percent tax on excess distributions may be offset by the 10 percent tax on early distributions to the extent that the 10 percent tax is applied to excess distributions. For example, assume that individual (A), age 56, receives a distribution of $200,000 from a qualified employer plan (Plan X) during calendar year 1987. Further, assume that the entire distribution is subject to the 10-percent tax of section 72(t). A tax of $20,000 (10% of $200,000) is imposed on the distribution under section 72(t). Assuming that the distribution is not a lump sum distribution eligible for special tax treatment under section 402, part of the distribution is subject to tax under section 4981A. If A does not elect the special grandfather rule, A's dollar limitation is $150,000 and the amount of $200,000 distribution that is an excess distribution is $50,000 ($200,000–$150,000). The 15 percent tax is $7,500 (15% of $50,000). The portion of the $20,000 section 72(t) tax on early distributions that is attributable to the excess distribution is $5,000 (10% of $50,000). This amount is credited against the section 4981A tax. Therefore, the total tax imposed on the distribution under both provisions is $22,500 ($20,000 + ($7,500–$5,000)).

(b) *Example.* (1) If some, but not all, distributions made for a calendar year are subject to the section 72(t) tax, the offset is applied only to the extent that the section 72(t) tax applies to amounts that exceed the applicable threshold amount for that calendar year. For example, assume that during 1987 individual B receives a distribution of $40,000 that is not subject to the 10 percent section 72(t) tax and a separate distribution of $160,000 that is subject to the 10 percent section 72(t) tax. A tax of $16,000 (10% of $160,000) is imposed by section 72(t). Excess distributions for the year, assuming B does not elect the special grandfather rule, are $50,000 ($40,000 + $160,000–$150,000). The tax under section 4981A is $7,500 (15% of $50,000). For purposes of determining

the extent to which the 10 percent tax is applied to excess distributions, the only amounts subject to the 10 percent tax that are taken into account are distributions in excess of $150,000 (or if greater, the $112,500 (indexed) threshold for the year). The amount of distributions for 1987 to which the 10 percent tax is applicable ($160,000) exceeds $150,000 by $10,000. Thus, the portion of the section 72(t) tax of $16,000 that is attributable to excess distributions equals $1,000 (10 percent of $10,000). This amount is credited against the section 4981A tax. The total tax payable under the provisions of sections 72(t) and 4981A is $22,500 ($16,000 + ($7,500–$1,000)).

(c) *Net unrealized appreciation*. A distribution consisting of net unrealized appreciation of employer securities that is excluded from gross income is not subject to section 72(t) and, therefore, there is no section 72(t) tax on such distribution that may be used to offset the tax on excess distributions.

c–5: Q. If a distribution that is subject to both the 10 percent tax on early distributions from qualified plans imposed under section 72(t) and the 15 percent tax on excess distributions imposed under section 4981A is received by an individual who elects to calculate the 15 percent tax using the special grandfather rule, how is the offset of the 10 percent tax imposed under section 72(t) calculated?

A. The section 4981A tax is reduced only by the amount of the 10 percent tax that is attributable to the portion of the distribution to which the section 4981A tax applies. For example, assume that (a) an individual (A), age 57, receives during 199X a distribution from a qualified plan of $325,000 that is subject to the 10 percent section 72(t) tax; (b) the distribution is not a lump sum distribution and is subject to the 15 percent excise tax imposed by section 4981A; (c) A has elected to use the special grandfather rule; and (d) A accelerates the rate of recovery of the remaining grandfather amount of $250,000 so that only $75,000 of this distribution is subject to the section 4981A tax. Thus, the section 4981A tax is $11,250 (15% of $75,000). The portion of the section 72(t) 10 percent tax that is offset against the section 4981A tax of $11,250 is limited to $7,500 (10% of $75,000), the section 72(t) tax on the amount of distributions after taking into account the reduction under the grandfather rule.

c–6: Q. When do distributions become subject to the excise tax under section 4981A?

A. (a) *General rule*. Excess distributions made after December 31, 1986, are subject to the excise tax under section 4981A.

(b) *Transitional rule*—(1) *Termination*. Distributions prior to January 1, 1988, made on account of certain terminations of a qualified employer plan are not subject to tax under section 4981A. For a plan termination to be eligible for this transitional rule, the plan termination must occur before January 1, 1987. For purposes of applying the rules of section 4981A (except the reporting requirements), any such distribution is treated as if made on December 31, 1986. The distribution of an annuity contract is not an excepted distribution. See Q&A a–5 of this section.

(2) *Lump sum distributions*. A lump sum distribution that an individual who separates from service in 1986 receives in calendar year 1987 before March 16 is treated as a distribution received in 1986 if such individual elects to treat it as received in 1986 under the provisions of section 1124 of TRA '86. Thus, such a qualifying section 1124 distribution is not subject to tax under section 4981A for 1987. For purposes of applying the rules of section 4981A, the amount attributable to such distribution is included in the individual's August 1, 1986 accrued benefit and such distribution is treated as if made on December 31, 1986.

(3) *Grandfather amount recovery*. If an individual described in this paragraph elects the special grandfather rule, the entire amount of distributions described in subparagraph (1) or (2) of this paragraph (b) is treated as a recovery of the individual's grandfather amount because it is treated as received on December 31, 1986. Thus, the individual's outstanding grandfather amount as of the date of the distribution is reduced by the amount of such distribution.

c–7: Q. How is the tax on excess distributions or on excess accumulations under section 4981A reported?

A. (a) *Tax on excess distributions.* An individual liable for tax on account on excess distributions under section 4981A must complete Form 5329 and attach it to his income tax return for the taxable year beginning with or within the calendar year during which the excess distributions are received. The amount of the tax is reported on such form and in such manner as prescribed by the Commissioner.

(b) *Tax on excess accumulations*—(1) *General rule.* If, with respect to the estate of any individual, there is a tax under section 4981A(d) on account of the individual's excess accumulations, the amount of such tax is reported on Schedule S (Form 706 or 706NR). Schedule S must be filed on or before the due date under section 6075 including extensions, for filing the estate tax return. The tax under section 4981A(d) must be paid by the otherwise applicable due date for paying the estate tax imposed by chapter 11 even if, pursuant to section 6018(a), no return is otherwise required with respect to the estate tax imposed by chapter 11.

(2) *Earliest due date.* Notwithstanding paragraph (b)(1) of this c–7, the due date for filing Schedule S (Form 706) and paying the tax on excess accumulations under section 4981A(d) is not earlier than February 1, 1988. Thus, with respect to the estates of individuals dying in January through April of 1987, the due date for filing Schedule S (Form 706) and paying any tax owed under section 4981A(d) is not earlier than February 1, 1988, even if the due date for filing the Schedule 706 and paying the estate tax imposed by chapter 11 is an earlier date. Further, no interest or penalties will be charged for failure to pay any tax on excess accumulations under section 4981A before January 31, 1988.

c–8: Q. Does the fact that the benefits under a qualified retirement plan or individual retirement account are community property affect the determination of the excise tax under section 4981A?

A. Generally, no. The operation of community property law is disregarded in determining the amount of aggregate annual distributions. Thus, the excise tax under section 4981A is computed without regard to the spouse's community property interest in the individual's or decedent's distributions or accumulation. Also, any reporting to the individual by a trustee, must be done on an aggregate basis without regard to the community property law.

d. Excess Accumulations

d–1: Q. To what extent does section 4981A increase the estate tax imposed by chapter 11 with respect to the estates of any decedents?

A. Section 4981A(d) provides that the estate tax imposed by chapter 11 with respect to the estate of any decedent is increased by an amount equal to 15 percent of the decedent's excess accumulation. See Q&A d–2 through d–7 of this section for rules for determining the decedent's excess accumulation. See Q&A d–8 of this section concerning credits under section 2010 through 2016. See Q&A d–9 of this section for examples illustrating the determination of the increase in estate tax under section 4981A(d).

d–2: Q. How is the amount of a decedent's excess accumulation determined?

A. (a) *General rule.* A decedent's excess accumulation is the excess of (1) the aggregate value of the decedent's interests in all qualified employer plans and individual retirement plans (decedent's aggregate interest) as of the date of the decedent's death over (2) an amount equal to the present value of a hypothetical life annuity determined under Q&A d–7 of this section. If the personal representative for the individual's estate elects to value the property in the gross estate under section 2032, the applicable valuation date prescribed by section 2032 shall be substituted for the decedent's date of death.

(b) *Other rules.* See Q&A d–3 and d–4 of this section if the decedent or, where appropriate, the decedent's personal representative validly elects the special grandfather rule and has any unused grandfather benefit as of the date of his death. See Q&A d–5 and d–6 of this section to determine the decedent's aggregate interest.

d–3: Q. Does the special grandfather rule apply for purposes of determining the amount of the decedent's excess accumulation?

A. Yes. If a decedent prior to death (or the decedent's personal representative after death) makes an election that satisfied the procedures in Q&A b–3 of this section, the special grandfather rule applies.

d–4: Q. How is the decedent's excess accumulation determined if the special grandfather rule applies?

A. If the special grandfather rule applies, the decedent's excess accumulation is the excess of (a) the decedent's aggregate interest (determined under Q&A d–5 of this section) over (b) the greater of (1) the decedent's remaining unrecovered grandfather amount as of the date of the decedent's death, or (2) an amount equal to the present value of a hypothetical life annuity under Q&A d–7 of this section.

d–5. Q. How is the value of the decedent's aggregate interest as of the applicable valuation date under Q&A d–2 determined?

A. (a) *Method of valuation*. The value of the decedent's aggregate interest on the decedent's date of death is determined in a manner consistent with the valuation of such interests for purposes of determining the individual's gross estate for purposes of chapter 11. If the personal representative for an individual's estate subject to estate tax elects to value the property in the gross estate under section 2032, the decedent's aggregate interest is valued in a manner consistent with the rules prescribed by section 2032 (and other relevant estate tax sections). No adjustments provided in chapter 11 in valuing the gross estate are made. Thus, there is no adjustment under section 2057 (relating to the sale of certain employer securities).

(b) *Amounts included*. Generally, all amounts payable to beneficiaries of the decedent under any qualified employer plan (including amounts payable to a surviving spouse under a qualified joint and survivor annuity or qualified preretirement survivor annuity) or individual retirement plan, whether or not otherwise included in valuing the decedent's gross estate, are considered to be part of the decedent's interest in such plan.

(c) *Rollover after death*. If any amount is distributed from a qualified employer plan or individual retirement plan within the 60-day period ending on the decedent's date of death and is rolled over to an IRA after such date but within 60 days of the date distributed, the decedent's aggregate interest is increased by the amount rolled over, valued as of the date received by the IRA.

d–6. Q. Are there any reductions in the decedent's aggregate interest?

A. The decedent's aggregate interest is reduced by the following:

(a) *Amount payable to alternate payee*. The amount of any portion of the deceased individual's interest in a qualified employer plan that is payable to an alternate payee in whose income the amount is includible under a qualified domestic relations order within the meaning of section 414(p) (QDRO). However, such portion must be taken into account in determining the excess distribution or the excess accumulation upon the death of such alternate payee for purposes of determining if there is a tax under section 4981A(a) or an increase in the estate tax under section 4981A(d) with respect to such alternate payee.

(b) *Investment in the contract*. The amount of the deceased individual's unrecovered investment, within the meaning of section 72(f), in any qualified employer plan or individual retirement plan.

(c) *Life insurance proceeds*. The excess of any amount payable by reason of the death of the individual under a life insurance contract held under a qualified employer plan over the cash surrender value of such contract immediately before the death of such individual (the amount excludible from income by reason of section 101(a)). Amounts excludible from gross income because of section 101(b) do not reduce the decedent's aggregate interest.

(d) *Interest as a beneficiary*. The amount of the deceased individual's interest in a qualified retirement plan or individual retirement plan by reason of the death of another individual.

d–7. Q. How is the present value of the hypothetical life annuity determined?

A. (a) *General rule*. The hypothetical life annuity is a single life annuity contract that provides for equal annual annuity payments commencing on the

decedent's date of death for the life of an individual whose age is the same as the decedent's determined as of the date of the decedent's death. The amount of each annual payment is equal to the greater of $150,000 (unindexed) and $112,500 (as indexed until the date of death). If the decedent elected (or the decedent's personal representative elects) the special grandfather rule, the amount of each annual payment is $112,500 (as indexed until the date of death) even if there is no remaining grandfather amount.

(b) *Determination of age.* The decedent's age as of the decedent's date of death for purposes of valuing the hypothetical life annuity is the decedent's attained age (in whole years) as of the decedent's date of death. For example, if the decedent was born on February 2, 1930, and died on August 3, 1990, the decedent's age for purposes of valuing the hypothetical life annuity is 60.

(c) *Interest rate assumptions.* The present value of the single life annuity described above must then be calculated using the interest rate and mortality assumptions in § 20.2031–7 of the Estate Tax Regulations in effect on the date of death.

d–8: Q. Are any credits, deductions, exclusions, etc. that apply for estate tax purposes allowable as an offset against the excise tax under section 4981A(d) for excess accumulations?

A. No. No credits, deductions, exclusions, etc. that apply for estate tax purposes are allowed to offset the tax imposed under section 4981A(d). Thus, no credits under section 2010 through 2016 or other reductions permitted by Chapter 11 are allowable against the tax under section 4981A(d) for excess accumulations. For example, no credits are allowable for the unified credit against the estate tax, for state death taxes, or for gift taxes.

d–8A. Q. Is the estate liable for the excise tax of 15 percent on the amount of the decedent's excess accumulations?

A. Yes. In all events, the estate is liable for the excise tax of 15 percent on the amount of the decedent's excess accumulations. Transferee liability rules under chapter 11 do apply, however. Similarly, the reimbursement provisions of section 2205 also apply. Additionally, the rules generally applicable for purposes of determining the apportionment of the estate tax apply to the apportionment of the excise tax under section 4981A(d). Thus, the decedent's will or the applicable state apportionment law may provide that the executor is entitled to recover the tax imposed under section 4981A(d) attributable to any property from the beneficiary entitled to receive such property. However, absent such a provision in the decedent's will or in the applicable state apportionment law, the executor is not entitled to recover the tax imposed under section 4981A(d) attributable to any property from the beneficiary entitled to receive such property.

d–9: Q. How is the additional tax computed with respect to a decedent's estate under section 4981A(d)?

A. The determination of the additional tax under section 4981A(d) is illustrated by the following examples:

Example 1. (a) An individual (A) dies on February 1, 199X at age 70 and 9 months. As of A's date of death, A has an interest in a defined benefit plan described in section 401(a) (Plan X). Plan X has never provided for employee contributions. A has no section 72 (f) investment in Plan X. A does not have any interest in any other qualified employer plan or individual retirement plan. The alternate valuation date in section 2032 does not apply. A did not elect to have the special grandfather rule apply. A's interest in Plan X is in the form of a qualified joint and survivor annuity. The value of the remaining payments under the joint and survivor annuity as of A's date of death (determined under D–5) is $2,000,000.

(b) Because A is age 70 and 9 months of A's date of death, A's life expectancy as of A's date of death is calculated using age 70 (A's attained age in whole years on A's date of death). The factor from Table A of § 20.2031–7(f) used to determine the present value of a single life annuity for an individual age 70 is 6.0522. The greater of $150,000 or $112,500 indexed for 199X is 150,000. The present value of the hypothetical single life annuity is $907,830 ($150,000×6.0522)

(c) The amount of A's excess accumulation is $1,092,170, determined as follows: $2,000,000 (value of A's interest in Plan X) minus $907,830 (value of hypothetical single life annuity contract) equals $1,092,170.

(d) The increase in the estate tax under section 4981A(d) is $163,825 (15 percent of $1,092,170).

Example 2. (a) The facts are the same as in *Example 1,* except that A's interest in Plan X consists of the following:

(1) $2,000,000, value of employer-provided portion of a qualified joint and survivor annuity determined as of A's date of death using the interest and mortality assumptions in § 20.2031–7.

(2) $200,000, proceeds of a term life insurance contract (no cash surrender value before death).

(3) $100,000. amount (employer-provided portion) payable to A's former spouse pursuant to a QDRO.

(4) $100,000, amount of A's investment in Plan X.

(b) The value of A's interest in Plan X for purposes of calculating A's excess accumulation is still $2,000,000. The proceeds of the term life insurance contract, the amount payable under the QDRO, and the amount of A's investment in Plan X are excluded from such value.

Example 3. (a) The facts are the same as in *Example 1,* except that A elected the special grandfather rule. A's initial grandfather amount was $1,100,000. As of A's date of death, A had received $500,000 in distributions that were treated as a return of A's grandfather amount. Thus, A's unused grandfather amount is $600,000 ($1,100,000–$500,000). In 199X, assume that $112,500 indexed is still $112,500.

(b) A's excess retirement accumulation is determined as follows: $2,000,000 minus the greater of (1) $600,000 or (2) the present value of a period certain annuity of $112,500 a year for 16 years. The present value of a single life annuity of $112,500 a year for an individual age 70 is determined as follows: $112,500 × 6.0522=$680,827.25. $680,827.25 is greater than $600,000. Thus the amount of the excess retirement accumulation is $1,319,173 ($2,000,000 minus $680,827).

(c) The additional estate tax under section 4981A(d) is $197,875 (15 percent of $1,319,173).

Example 4. (a) The facts are the same as in *Example 3* except that, as of A's date of death, A received $90,000 in distributions that were treated as a return of A's grandfather amount. Thus, A's unused grandfather amount is $1,010,000 ($1,100,000–$90,000).

(b) A's excess retirement accumulation is determined as follows: $2,000,000 minus the greater of (1) ($1,010,000 (A's unused grandfather amount) or (2) 680,827.25 (the present value of a single life annuity of $112,500 a year for an individual age 70). A's unused grandfather amount is greater than the present value of the hypothetical life annuity. Thus, the amount of the excess retirement accumulation is $990,000 ($2,000,000–$1,010,000).

(c) The additional estate tax under section 4981A(d) is $148,500 (15 percent of $990,000).

d–10: Q. if a surviving spouse rolls over a distribution from a qualified retirement plan or an individual retirement plan of the decedent to an individual retirement plan (IRA) established in the spouse's own name, is any distribution in a calendar year from the IRA receiving such rollover included in determining the spouse's excess distribution or excess accumulation in such calendar year?

A. (a) *General rule.* If a surviving spouse rolls over a distribution from a qualified retirement plan or an individual retirement plan of the decedent to an individual retirement plan (IRA) established in the spouse's own name with the rollover contribution and no other contributions or transfers are made to the IRA receiving the rollover contribution, distributions from such IRA will be excluded in determining the spouse's excess distributions and the value of the IRA will be excluded in determining the spouse's excess accumulation. If the surviving spouse rolls over a distribution from a qualified retirement plan or IRA of the decedent to an IRA for which the spouse has prior contributions or makes additional contributions to the IRA receiving the distribution, distributions from the IRA will be included in determining the amount of the excess distributions received by the spouse for the calendar year of the distribution and the value of the IRA at the applicable valuation date will be included in determining the spouse's excess accumulation.

(b) *Special rules.* The rule in paragraph (a) of this Q&A d–10 also applies if a surviving spouse elects to treat an inherited IRA (described in section 408(d)(3)(C)(ii)) as the spouse's own IRA as long as the surviving spouse makes no further contributions to such IRA.

(c) *Other beneficiaries.* Rules similar to the rules in paragraphs (a) and (b) shall apply to an individual who elected to treat an IRA as subject to the distribution requirements of section 408(a)(6), prior to amendment by section 521(b) of TRA '84, under § 1.408–2(b)(7)(ii) of the Income Tax Regulations.

d–11. Q. To what estates does the excise tax under section 4981A(d) apply?

A. The excise tax under section 4981A(d) applies to estates of decedents dying after December 31, 1986.

d–12: Q. Is the aggregate interest reduced by distributions described in paragraph (b)(1) of Q&A c–6 of this section (distributions prior to January 1, 1988, made on account of certain terminations of a qualified employer plan) which are made after the individual's death.

A. Yes, the value of the individual's aggregate interest determined under Q&A d–5 of this section is reduced by distributions described in paragraph (b)(1) of Q&A c–6 of this section which are made after the individual's death.

[T.D. 8165, 52 FR 46750, Dec. 10, 1987; 53 FR 18975, May 26, 1988]

§ 54.6011–1 General requirement of return, statement, or list.

(a) *Minimum funding standards or excess contributions for self-employed individuals and section 403(b)(7)(A) custodial accounts*. Any employer or individual liable for tax under section 4971, 4972 or 4973(a)(2) (for a custodial account under section 403(b)(7)(A)) shall file an annual return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto.

(b) *Tax on prohibited transactions*. Every disqualified person (as defined in section 4975(e)(2)) liable for the tax imposed under section 4975(a) with respect to a prohibited transaction shall file an annual return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto. The annual return on Form 5330 shall be filed with respect to each prohibited transaction and for each taxable year (or part thereof) of the disqualified person in the taxable period (as defined in section 4975(f)(2)) beginning on the date on which such prohibited transaction occurs.

(c) *Entity manager tax on prohibited tax shelter transactions*—(1) *In general*. Any entity manager of a tax-exempt entity described in section 4965(c)(4), (c)(5), (c)(6), or (c)(7) who is liable for tax under section 4965(a)(2) shall file a return on Form 5330, ''Return of Excise Taxes Related to Employee Benefit Plans,'' on or before the 15th day of the fifth month following the close of such entity manager's taxable year during which the entity entered into the prohibited tax shelter transaction, and shall include therein the information required by such form and the instructions issued with respect thereto.

(2) *Transition rule*. A Form 5330, ''Return of Excise Taxes Related to Employee Benefit Plans,'' for an excise tax under section 4965 that was due on or before October 4, 2007, will be deemed to have been filed on the due date if it was filed by October 4, 2007, and if the section 4965 tax that was required to be reported on that Form 5330 was paid by October 4, 2007.

(d) *Effective/applicability date*. Paragraph (c) of this section is applicable on July 6, 2007.

[T.D. 7838, 47 FR 44249, Oct. 7, 1982, as amended by T.D. 9334, 72 FR 36873, July 6, 2007; T.D. 9492, 75 FR 38708, July 6, 2010; 75 FR 46845, Aug. 4, 2010]

§ 54.6011–1T General requirement of return, statement, or list (temporary).

(a) *Tax on reversions of qualified plan assets to employer*. Every employer liable for the tax imposed under section 4980(a) with respect to an employer reversion (as defined in section 4980(c)(2)) shall file a quarterly return on Form 5330 and shall include therein the information required by such form and the instructions issued with respect thereto. The quarterly return on Form 5330 shall be filed with respect to employer reversions from each qualified plan (as defined in section 4980(c)(1)).

(b) [Reserved]

[T.D. 8133, 52 FR 10563, Apr. 2, 1987 as amended by T.D. 9334, 72 FR 36873, July 6, 2007; 72 FR 45895, Aug. 16, 2007; T.D. 9492, 75 FR 38709, July 6, 2010]

§ 54.6011–2 General requirement of return, statement, or list.

Effective for any Form 8928 that is due on or after January 1, 2010, any person liable for tax under section 4980B, 4980D, 4980E, or 4980G of the Code shall file a return with respect to the tax on Form 8928. The return must include the information required by Form 8928 and the instructions issued with respect to it.

[T.D. 9457, 74 FR 45999, Sept. 8, 2009]

§ 54.6011–4 Requirement of statement disclosing participation in certain transactions by taxpayers.

(a) *In general.* If a transaction is identified as a *listed transaction* or a *transaction of interest* as defined in § 1.6011–4 of this chapter by the Commissioner in published guidance (see § 601.601(d)(2)(ii)(*b*) of this chapter), and the listed transaction or transaction of interest involves an excise tax under chapter 43 of subtitle D of the Internal Revenue Code (relating to qualified pension, etc., plans) the transaction must be disclosed in the manner stated in such published guidance.

(b) *Effective/applicability date.* This section applies to listed transactions entered into on or after January 1, 2003. This section applies to transactions of interest entered into on or after November 2, 2006.

[T.D. 9350, 72 FR 43154, Aug. 3, 2007]

§ 54.6060–1 Reporting requirements for tax return preparers.

(a) *In general.* A person that employs one or more tax return preparers to prepare a return or claim for refund under Chapter 43 of subtitle D of the Internal Revenue Code, other than for the person, at any time during a return period, shall satisfy the record keeping and inspection requirements in the manner stated in § 1.6060–1 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 78458, Dec. 22, 2008]

§ 54.6061–1 Signing of returns and other documents.

Effective for any Form 8928 that is due on or after January 1, 2010, any return, statement, or other document required to be made with respect to a tax imposed by section 4980B, 4980D, 4980E, or 4980G of the Code or the regulations under section 4980B, 4980D, 4980E, or 4980G must be signed by the person required to file the return, statement, or other document, or by the persons required or duly authorized to sign in accordance with the regulations, forms, or instructions prescribed with respect to such return, statement, or document. An individual's signature on such return, statement, or other document shall be prima facie evidence that the individual is authorized to sign the return, statement, or other document.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6071–1 Time for filing returns.

(a) *Returns under section 4980B.* (1) *Due date for filing of return by employers or other persons responsible for benefits under a group health plan.* If the person liable for the excise tax is an employer or other person responsible for providing or administering benefits under a group health plan (such as an insurer or a third party administrator), the return required by § 54.6011–2 must be filed on or before the due date for filing the person's income tax return and must reflect the portion of the noncompliance period for each failure under section 4980B that falls during the person's taxable year. An extension to file the person's income tax return does not extend the date for filing Form 8928.

(2) *Due date for filing of return by multiemployer plans.* If the person liable for the excise tax is a multiemployer plan, the return required by § 54.6011–2 must be filed on or before the last day of the seventh month following the end of the plan's plan year. The filing of Form 8928 by a plan must reflect the portion of the noncompliance period for each failure under section 4980B that falls during the plan's plan year.

(b) *Returns under section 4980D.* (1) *Due date for filing of return by employers.* If the person liable for the excise tax is an employer, the return required by § 54.6011–2 must be filed on or before the due date for filing the employer's income tax return and must reflect the portion of the noncompliance period for each failure under chapter 100 that falls during the employer's taxable year. An extension to file the employer's income tax return does not extend the date for filing Form 8928.

(2) *Due date for filing of return by multiemployer plans or multiple employer health plans.* If the person liable for the excise tax is a multiemployer plan or a specified multiple employer health plan, the return required by § 54.6011–2 must be filed on or before the last day of the seventh month following the end

of the plan's plan year. The filing of Form 8928 by a plan must reflect the portion of the noncompliance period for each failure under chapter 100 that falls during the plan's plan year.

(c) *Returns under section 4980E.* Any employer who is liable for the excise tax under section 4980E must report this tax by filing the return required by § 54.6011–2 on or before the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made.

(d) *Returns under section 4980G.* Any employer who is liable for the excise tax under section 4980E must report this tax by filing the return required by § 54.6011–2 on or before the 15th day of the fourth month following the calendar year in which the noncomparable contributions were made. *See* Q & A–4 of § 54.4980G–1 for the rules on computation of the excise tax under section 4980G.

(e) *Effective/applicability date:* The rules in this section are effective for any Form 8928 that is due on or after January 1, 2010.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6081–1 Automatic extension of time for filing returns for certain excise taxes under Chapter 43.

(a) *In general.* An employer, other person or health plan that is required to file a return on Form 8928, ''Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code,'' will be allowed an automatic 6-month extension of time to file the return after the date prescribed for filing the return if the employer, other person or health plan files an application under this section in accordance with paragraph (b) of this section.

(b) *Requirements.* To satisfy this paragraph (b), an employer, other person or health plan must—

(1) Submit a complete application on Form 7004, ''Application for Automatic Extension of Time To File Certain Business Income Tax, Information, and Other Returns,'' or in any other manner prescribed by the Commissioner;

(2) File the application on or before the date prescribed for filing the return with the Internal Revenue Service office designated in the application's instructions; and

(3) Remit the amount of the properly estimated unpaid tax liability on or before the date prescribed for payment.

(c) *No extension of time for the payment of tax.* An automatic extension of time for filing a return granted under paragraph (a) of this section will not extend the time for payment of any tax due on such return.

(d) *Termination of automatic extension.* The Commissioner may terminate an automatic extension at any time by mailing to the employer, other person, or health plan a notice of termination at least 10 days prior to the termination date designated in such notice. The Commissioner must mail the notice of termination to the address shown on the Form 7004 or to the estate or trust's last known address. For further guidance regarding the definition of last known address, *see* § 301.6212–2 of this chapter.

(e) *Penalties. See* section 6651 for failure to file a pension excise tax return or failure to pay the amount shown as tax on the return.

(f) *Effective/applicability date.* This section is applicable for applications for an automatic extension of time to file a return due under chapter 43, filed on or after June 24, 2011.

[T.D. 9531, 76 FR 36999, June 24, 2011]

§ 54.6091–1 Place for filing excise tax returns under section 4980B, 4980D, 4980E, or 4980G.

Effective for any Form 8928 that is due on or after January 1, 2010, the return required by § 54.6011–2 must be filed at the place specified in the forms and instructions provided by the Internal Revenue Service.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6107–1 Tax return preparer must furnish copy of return or claims for refund to taxpayer and must retain a copy or record.

(a) *In general.* A person who is a signing tax return preparer of any return or claim for refund of tax under Chapter 43 of subtitle D of the Internal Revenue Code, shall furnish a completed copy of the return or claim for refund to the taxpayer, and retain a completed copy or record in the manner stated in § 1.6107–1 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 78458, Dec. 22, 2008]

§ 54.6109–1 Tax return preparers furnishing identifying numbers for returns or claims for refund filed.

(a) *In general.* Each tax return or claim for refund of tax under Chapter 43 of subtitle D prepared by one or more signing tax return preparers must include the identifying number of the preparer required by § 1.6695–1(b) of this chapter to sign the return or claim for refund in the manner stated in § 1.6109–2 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6151–1 Time and place for paying of tax shown on returns.

Effective for any Form 8928 that is due on or after January 1, 2010, the tax shown on any return which is imposed under section 4980B, 4980D, 4980E or 4980G shall, without assessment or notice and demand, be paid to the internal revenue officer with whom the return is filed at the time and place for filing such return (determined without regard to any extension of time for filing the return). For provisions relating to the time and place for filing such return, *see* §§ 54.6071–1 and 54.6091–1.

[T.D. 9457, 74 FR 46000, Sept. 8, 2009]

§ 54.6694–1 Section 6694 penalties applicable to tax return preparer.

(a) *In general.* For general definitions regarding section 6694 penalties applicable to preparers of tax returns or claims for refund of tax under Chapter 43 of subtitle D, see § 1.6694–1 of this chapter.

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

[T.D. 9436, 73 FR 78458, Dec. 22, 2008]

§ 54.6694–2 Penalties for understatement due to an unreasonable position.

(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 under section 6694(a) of the Code in the manner stated in § 1.6694–2 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 78458, Dec. 22, 2008]

§ 54.6694–3 Penalty for understatement due to willful, reckless, or intentional conduct.

(a) *In general.* A person who is a tax return preparer of any return or claim for refund of excise tax under chapter 43 of subtitle D of the Internal Revenue Code (Code) shall be subject to penalties under section 6694(b) of the Code in the manner stated in § 1.6694–3 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 78458, Dec. 22, 2008]

§ 54.6694–4 Extension of period of collection when tax return preparer pays 15 percent of a penalty for understatement of taxpayer's liability and certain other procedural matters.

(a) *In general.* For rules relating to the extension of period of collection 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 § 54.9831–1(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 certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

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 ERISA). 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 PHS Act);

(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. 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 PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer*.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 54.9801–3(a)(3)(v) and (vi) .

Medical care has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

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.

Participant means *participant* within the meaning of section 3(7) of ERISA.

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 ends 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 or 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 (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR part 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to Federally eligible individuals pursuant to 45 CFR part 148), 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 § 54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

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 less than 12 months after the original effective date of the contract.

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in § 54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4(a)(1)(vii).

Waiting period means *waiting period* within the meaning of § 54.9801–3(a)(3)(iii).

[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 62420, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009; T.D. 9491, 75 FR 37222, June 28, 2010]

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a *preexisting condition exclusion* within the meaning set forth in § 54.9801–2.

(ii) *Examples*. The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan provides benefits solely through an insurance policy offered by Issuer *S*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion*. In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts*. A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion*. In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts*. A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of $10,000.

(ii) *Conclusion*. In this *Example 3*, the $10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts*. A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of $2,000. The plan counts against this $2,000 lifetime limit on acne treatment benefits provided under prior health coverage.

(ii) *Conclusion*. In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts*. When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion*. In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph

(b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied. (*See* section 701 of ERISA and section 2701 of the PHS Act, under which these requirements are also imposed on a health insurance issuer offering group health insurance coverage.)

(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 (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(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)(2)(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)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1*, Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because *A* received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan

would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2*, Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3*, the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 54.9802–1, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4*, Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* 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 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; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) 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 § 54.9801–4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 54.9801–5(a)), or through other means in accordance with the rules of § 54.9801–5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y*. *Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example*, *Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 54.9802–1 for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, 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 or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* 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 *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 on October 14, 1998 *E* 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) *Conclusion.* In this *Example 1*, *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 permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2*, *B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3*, *E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on

May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), the plan may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, the plan still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy). See 29 CFR 2590.701–3(a)(3)(iv) *Example 3* and 45 CFR 146.111(a)(3)(iv) *Example 3* for a conclusion that Issuer *T* is similarly prohibited from imposing a preexisting condition exclusion with respect to *E*.

Example 4. (i) *Facts*. A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion*. In this *Example 4*, *C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts*. To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion*. In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 54.9801–6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility 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.

(vii) *Examples*. The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. 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 a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion*. In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that *F* 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) *Conclusion*. 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 may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child 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 (as described in § 54.9801–4(b)(2)(iii)), the

other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples*. The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion*. In this *Example 1*, because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts*. Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion*. In this *Example 2*, the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children*. Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage*. Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 54.9801–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment*. For special enrollment rules relating to new dependents, see § 54.9801–6(b).

(5) *Pregnancy*. A group health plan may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts*. Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion*. In this *Example*, the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided. (See 29 CFR 2590.701–3(c) and 45 CFR 146.111(c), which also impose this requirement on a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion.)

(1) *Manner and timing.* A plan must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan for enrollment. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18 months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 54.9801–5(a)) or through other means (as described in § 54.9801–5(c)). This must include 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 will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual by another party, the plan's obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(c)(3) and 45 CFR 146.111(c)(3), which provide that the issuer's obligation is similarly satisfied.)

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-

month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N*.

(ii) *Conclusion*. In this *Example*, the plan satisfies the general notice requirement of this paragraph (c).

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time*. If a group health plan receives creditable coverage information under § 54.9801–5, the plan is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends 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 care. (See 29 CFR 2590.701–3(d) and 45 CFR 146.111(d), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(2) *No time limit on presenting evidence of creditable coverage*. A plan may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example*. The rules of this paragraph (d) are illustrated by the following example:

Example. (i) *Facts*. A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *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 in accordance with the rules of § 54.9801–5.

(ii) *Conclusion*. In this *Example*, the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion*. After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage under paragraph (d) of this section, the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan is not required to provide this notice if the plan does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. (See 29 CFR 2590.701–3(e) and 45 CFR 146.111(e), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(1) *Manner and timing*. The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content*. A plan must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan.

(3) *Duplicate notices not required*. If a notice satisfying the requirements of this paragraph (e) is provided to an individual by another party, the plan's obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is

satisfied. (See 29 CFR 2590.701–3(e)(3) and 45 CFR 146.111(e)(3), which provide that the issuer's obligation is similarly satisfied.)

(4) *Examples*. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion*. In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts*. Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion*. In this *Example 2*, the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration*. Nothing in this section prevents a plan from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004, as amended by T.D. 9491, 75 FR 37223, June 28, 2010]

§ 54.9801–4 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 § 54.9831–1(a).

(ii) Health insurance coverage as defined in § 54.9801–2 (whether or not the entity offering the coverage is subject to Chapter 100 of Subtitle K, 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);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; 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 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, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health 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)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage*. Creditable coverage does not include coverage of solely excepted benefits (described in § 54.9831–1).

(3) *Methods of counting creditable coverage*. For purposes of reducing any preexisting condition exclusion period, as provided under § 54.9801–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan 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 or may provide that a health insurance issuer offering health insurance coverage under the plan may use the alternative method of counting creditable coverage.

(b) *Standard method*—(1) *Specific benefits not considered*. Under the standard method, the amount of creditable coverage is determined 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 that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has 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. Any days in a waiting period for coverage are not creditable coverage.

(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) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (*See* section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHS Act, 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) *Periods that toll a significant break*. Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples*. The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, *A* is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion*. In this *Example 1*, *A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion*. 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, *Q*'s plan must count *A*'s prior

creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A*.

Example 3. (i) *Facts*. Same facts as *Example 1*, except that *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) *Conclusion*. In this *Example 3*, under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. [Reserved]

Example 5. (i) *Facts*. Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T*, *C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion*. In this *Example 5*, *C* does not have a significant break in coverage because, after disregarding the waiting period under *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 *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. [Reserved]

Example 7. (i) *Facts*. Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion*. In this *Example 7*, because *E* applied for the policy before the end of the 63rd day, 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 73 days.

Example 8. (i) *Facts*. Same facts as *Example 7*, except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion*. In this *Example 8*, even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *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 § 54.9801–5), a group health plan 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)(vi) is illustrated by the following example:

Example. (i) *Facts*. 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.

(ii) *Conclusion*. In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (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 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 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 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 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 using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan. A plan that provides benefits (in part or in whole) through one or more policies or contracts of insurance will not fail the uniform application requirement of this paragraph (c)(2) if the alternative method is used (or not used) separately with respect to participants and beneficiaries under any policy or contact, provided that the alternative method is applied uniformly with respect to all coverage under that policy or contract. 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 §54.9801–5(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 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)), 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 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 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 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) *Facts*. 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) *Conclusion*. 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.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004]

§ 54.9801–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan is required to furnish certificates of creditable coverage in accordance with this paragraph (a). (See section 701(e) of ERISA and section 2701(e) of the PHS Act, under which this obligation is also imposed on each health insurance issuer offering group health insurance coverage under the plan.)

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity 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 satisfies the certification requirements under this paragraph (a) 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 an employer sponsoring a plan 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 plan does not violate the certification requirements of this paragraph (a) (though the issuer would have violated the certification requirements pursuant to section 701(e) of ERISA and section 2701(e) of the PHS Act).

(iv) *Special rules relating to issuers providing coverage under a plan*—(A)(1) *Responsibility of issuer for coverage period.* See 29 CFR 2590.701–5 and 45 CFR 146.115, under which an issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule referenced by this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* 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) *Conclusion.* 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 or contract ceases before the individual's coverage under the plan ceases, the issuer is required (under section 701(e) of ERISA and section 2701(e) of the PHS Act) to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may

presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(*1*) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(*2*) *Example*. The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) *Facts*. A group health plan provides coverage under an HMO option and an indemnity option through different issuers, 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) *Conclusion*. In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the indemnity 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 4980B(g)(3)) 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 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 4980B(f)(6) (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 must be provided at the time the individual ceases to be covered under the plan. A plan satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered 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).

(*1*) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(*2*) 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 after coverage ceases under the plan.

(*3*) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(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 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.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 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, 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 rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* 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) *Conclusion.* In this *Example 1,* the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) *Facts.* 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) *Conclusion.* In this *Example 2,* the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* 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 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) *Conclusion.* In this *Example 3,* the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* 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, *S's* group health plan determines that *C's* COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* 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) *Facts.* 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 *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) *Conclusion.* 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 who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(*2*) 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 (such as by telephone); and

(*3*) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time 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;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(*1*) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(*2*) Special enrollment rights;

(*3*) The prohibitions against discrimination based on any health factor;

(*4*) The right to individual health coverage;

(*5*) The fact that State law may require issuers to provide additional protections to individuals in that State; and

(*6*) Where to get more information.

(iii) *Periods of coverage under the 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, the certificate provided must include 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. 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 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 § 54.9831–1(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 54.9801–4(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 written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(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 individual or entity. 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 individual or entity.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan 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 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)(i) are illustrated by the following example:

Example. (i) *Facts.* 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) *Conclusion.* In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) of this section 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 covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. See also § 54.9801–3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Chapter 100 of Subtitle K*—(i) *Issuers.* For rules requiring that issuers in the group and individual markets provide certificates consistent with the rules in this section, see section 701(e) of ERISA and sections 2701(e), 2721(b)(1)(B), and 2743 of the PHS Act.

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Chapter 100 of Subtitle K provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to nonfederal governmental plans generally, and section 2721(b)(2)(C)(ii) of the PHS Act 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 PHS Act.

(b) *Disclosure of coverage to a plan or issuer using the alternative method of*

counting creditable coverage—(1) *In general*. After an individual provides a certificate of creditable coverage to a plan (or issuer) using the alternative method under § 54.9801–4(c), that plan (or issuer) (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(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.

(3) *Charge for providing information*. The prior entity 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) *Purpose*. The rules in this paragraph (c) implement section 9801(c)(4), which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 9801(e)(3), 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.

(2) *In general*. If the accuracy of a certificate is contested or a certificate is unavailable when needed by an 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;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage*—(i) *Consideration of evidence*—(A) A plan 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. A plan shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(*1*) The individual attests to the period of creditable coverage;

(*2*) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(*3*) The individual cooperates with the plan's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan 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 may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents*. Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (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 or affiliation periods) may also be corroborated 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)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *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, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *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) *Conclusion.* In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of 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).

(5) *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.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004]

§ 54.9801–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan is required to permit current employees and dependents (as defined in § 54.9801–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. 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. (See section 701(f)(1) of ERISA and section 2701(f)(1) of the PHS Act, under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment*—(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage*—(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had

coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples*. The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts*. Individual *A* works for Employer *X*. *A*, *A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under X's group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under X's plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion*. In this *Example 1*, because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts*. Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion*. In this *Example 2*, because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts*. Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion*. In this *Example 3*, because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts*. Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion*. In this *Example 4*, because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage*. In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent 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). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because

an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802–1(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 54.9801–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1*, employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2*, *A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health

plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3*, *C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. 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. (*See* 29 CFR 2590.701–6(b) and 45 CFR 146.117(b), under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in §54.9801–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph

(b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan (or any issuer offering health insurance coverage under the plan) receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1*, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A*, *B*, and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies

under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required*. The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 54.9801–3(b).

(3) The rules of this section are illustrated by the following example:

Example 2. (i) *Facts*. Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion*. In this *Example*, *B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

[T.D. 9166, 69 FR 78746, Dec. 30, 2004]

§ 54.9802–1 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 § 54.9801–2;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in § 54.9802–3T.

(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 § 54.9801–6, a plan 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 may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan

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 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 or 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.* See *Example 4* in 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) for a conclusion that the exclusion by the issuer of *A* and *A*'s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors and violates rules under 29 CFR 2590.702(b)(1) and 45 CFR 146.121(b)(1) similar to the rules under 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 violates this paragraph (b)(1).

(2) *Application to benefits*—(i) *General rule*—(A) Under this section, a group health plan is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan 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 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 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 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 ERISA, 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.* The facts of this *Example 2* strongly suggest that the plan modification is directed at *B* based on *B*'s claim. Absent outweighing evidence to the contrary, the plan violates this paragraph (b)(2)(i).

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.* See *Example 3* in 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) for a conclusion that the issuer violates rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i) similar to the rules under 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 the rules under 29 CFR 2590.702(b)(2)(i) and 45 CFR 146.121(b)(2)(i). If the plan provides coverage through this policy and does not provide equivalent coverage for *C* through other means, the plan 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 $2,000 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. (This example does not address whether the plan provision is permissible under the Americans with Disabilities Act or any other applicable law.)

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.

Example 8. (i) *Facts.* An employer sponsors a group health plan that is available to all current employees. Under the plan, the medical care expenses of each employee (and the employee's dependents) are reimbursed up to an annual maximum amount. The maximum reimbursement amount with respect to an employee for a year is $1500 multiplied by the number of years the employee has participated in the plan, reduced by the total reimbursements for prior years.

(ii) *Conclusion.* In this *Example 8*, the variable annual limit does not violate this paragraph (b)(2)(i). Although the maximum reimbursement amount for a year varies among employees within the same group of similarly situated individuals based on prior claims experience, employees who have participated in the plan for the same length of time are eligible for the same total benefit over that length of time (and the restriction on the maximum reimbursement amount is not directed at any individual participants or beneficiaries based on any health factor).

(ii) *Exception for wellness programs.* A group health plan may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment, or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(iii) *Specific rule relating to source-of-injury exclusions*—(A) If a group health plan generally provides benefits for a type of injury, the plan 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). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

(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. Because of depression, Individual *D* attempts suicide. As a result, *D* sustains injuries and is hospitalized for treatment of the injuries. Under 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 § 54.9801–3.* (i) A preexisting condition exclusion is permitted under this section if it—

(A) Complies with § 54.9801–3;

(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 § 54.9801–3. 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 § 54.9801–3 (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 may not require an 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 (described in paragraph (d) of this section) enrolled in the plan 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. But *see* § 54.9802–3T(b), which prohibits adjustments in group premium or contribution rates based on genetic information.

(ii) *List billing based on a health factor prohibited.* However, 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.* See *Example 1* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer does not violate the provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to 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. (However, those examples conclude that if the issuer used genetic information in computing the group rate, it would violate 29 CFR 2590.702–1(b) or 45 CFR 146.122(b).)

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.* See *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer violates provisions of 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) similar to the provisions of 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, see *Example 2* in 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) for a conclusion that the issuer would still violate 29 CFR 2590.702(c)(2) and 45 CFR 146.121(c)(2) (but in such a case the plan would not violate this paragraph (c)(2)).

(3) *Exception for wellness programs.* Notwithstanding paragraphs (c)(1) and (2) of this section, a plan may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of paragraph (f) of this section.

(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 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 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 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 (for example, 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 usual 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 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 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, 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*. See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for a conclusion that Issuer *N* violates provisions of 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) similar to the provisions of this paragraph (e)(1) because the group health insurance coverage restricts benefits based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits from a previous issuer. See *Example 2* in 29 CFR 2590.702(e)(1) and 45 CFR 146.121(e)(1) for the additional conclusions that under State law Issuer *M* may also be responsible for providing benefits to such a dependent; and that in a case in which Issuer *N* has an obligation under 29 CFR 2590.702(e)(1) or 45 CFR 146.121(e)(1) to provide benefits and Issuer *M* has an obligation under State law to provide benefits, any State laws designed to prevent more than 100% reimbursement, such as State coordination-of-benefits laws, continue to apply.

(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 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, 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 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 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 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.)

(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) *Wellness programs.* A wellness program is any program designed to promote health or prevent disease. Paragraphs (b)(2)(ii) and (c)(3) of this section provide exceptions to the general prohibitions against discrimination

based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this paragraph (f). If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, paragraph (f)(1) of this section clarifies that the wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of paragraph (f)(2) of this section are met.

(1) *Wellness programs not subject to requirements.* If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate this section, if participation in the program is made available to all similarly situated individuals. Thus, for example, the following programs need not satisfy the requirements of paragraph (f)(2) of this section, if participation in the program is made available to all similarly situated individuals:

(i) A program that reimburses all or part of the cost for memberships in a fitness center.

(ii) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(iii) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.

(iv) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.

(v) A program that provides a reward to employees for attending a monthly health education seminar.

(2) *Wellness programs subject to requirements.* If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program does not violate this section if the requirements of this paragraph (f)(2) are met.

(i) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, must not exceed 20 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward must not exceed 20 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(2), the cost of coverage is determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

(ii) The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(iii) The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(iv) The reward under the program must be available to all similarly situated individuals.

(A) A reward is not available to all similarly situated individuals for a period unless the program allows—

(*1*) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(*2*) A reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

(B) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

(v)(A) The plan must disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under paragraph (f)(2)(iv) of this section. However, if plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.

(B) The following language, or substantially similar language, can be used to satisfy the requirement of this paragraph (f)(2)(v): ''If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.'' In addition, other examples of language that would satisfy this requirement are set forth in *Examples 3*, *4*, and *5* of paragraph (f)(3) of this section.

(3) *Examples*. The rules of paragraph (f)(2) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan. The annual premium for employee-only coverage is $3,600 (of which the employer pays $2,700 per year and the employee pays $900 per year). The annual premium for family coverage is $9,000 (of which the employer pays $4,500 per year and the employee pays $4,500 per year). The plan offers a wellness program with an annual premium rebate of $360. The program is available only to employees.

(ii) *Conclusion*. In this *Example 1*, the program satisfies the requirements of paragraph (f)(2)(i) of this section because the reward for the wellness program, $360, does not exceed 20 percent of the total annual cost of employee-only coverage, $720. ($3,600 × 20% = $720.) If any class of dependents is allowed to participate in the program and the employee is enrolled in family coverage, the plan could offer the employee a reward of up to 20 percent of the cost of family coverage, $1,800. ($9,000 × 20% = $1,800.)

Example 2. (i) *Facts*. A group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists solely of giving an annual cholesterol test to participants. Those participants who achieve a count under 200 receive the premium discount for the year.

(ii) *Conclusion*. In this *Example 2*, the program fails to satisfy the requirement of being available to all similarly situated individuals because some participants may be unable to achieve a cholesterol count of under 200 and the plan does not make available a reasonable alternative standard or waive the cholesterol standard. (In addition, plan materials describing the program are required to disclose the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) for obtaining the premium discount. Thus, the premium discount violates paragraph (c) of this section because it may require an individual to pay a higher premium based on a health factor of the individual than is required of a similarly situated individual under the plan.

Example 3. (i) *Facts*. Same facts as *Example 2*, except that the plan provides that if it is unreasonably difficult due to a medical condition for a participant to achieve the targeted cholesterol count (or if it is medically inadvisable for a participant to attempt to achieve the targeted cholesterol count) within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. In addition, all plan materials describing the terms of the program include the following statement: ''If it is unreasonably difficult due to a medical condition for you to achieve a cholesterol count under 200,

or if it is medically inadvisable for you to attempt to achieve a count under 200, call us at the number below and we will work with you to develop another way to get the discount.'' Individual *D* begins a diet and exercise program but is unable to achieve a cholesterol count under 200 within the prescribed period. *D*'s doctor determines *D* requires prescription medication to achieve a medically advisable cholesterol count. In addition, the doctor determines that *D* must be monitored through periodic blood tests to continually reevaluate *D*'s health status. The plan accommodates *D* by making the discount available to *D*, but only if *D* follows the advice of *D*'s doctor's regarding medication and blood tests.

(ii) *Conclusion*. In this *Example 3*, the program is a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve the targeted count (or for whom it is medically inadvisable to attempt to achieve the targeted count) in the prescribed period by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium discount does not violate this section.

Example 4. (i) *Facts*. A group health plan will waive the $250 annual deductible (which is less than 20 percent of the annual cost of employee-only coverage under the plan) for the following year for participants who have a body mass index between 19 and 26, determined shortly before the beginning of the year. However, any participant for whom it is unreasonably difficult due to a medical condition to attain this standard (and any participant for whom it is medically inadvisable to attempt to achieve this standard) during the plan year is given the same discount if the participant walks for 20 minutes three days a week. Any participant for whom it is unreasonably difficult due to a medical condition to attain either standard (and any participant for whom it is medically inadvisable to attempt to achieve either standard) during the year is given the same discount if the individual satisfies an alternative standard that is reasonable in the burden it imposes and is reasonable taking into consideration the individual's medical situation. All plan materials describing the terms of the wellness program include the following statement: ''If it is unreasonably difficult due to a medical condition for you to achieve a body mass index between 19 and 26 (or if it is medically inadvisable for you to attempt to achieve this body mass index) this year, your deductible will be waived if you walk for 20 minutes three days a week. If you cannot follow the walking program, call us at the number above and we will work with you to develop another way to have your deductible waived.'' Due to a medical condition, Individual *E* is unable to achieve a BMI of between 19 and 26 and is also unable to follow the walking program. *E* proposes a program based on the *recommendations of E's* physician. The plan agrees to make the discount available to *E* if *E* follows the physician's recommendations.

(ii) *Conclusion*. In this *Example 4*, the program satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it generally accommodates individuals for whom it is unreasonably difficult due to a medical condition to achieve (or for whom it is medically inadvisable to attempt to achieve) the targeted body mass index by providing a reasonable alternative standard (walking) and it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to walk by providing an alternative standard that is reasonable for the individual. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard for every individual. Thus, the waiver of the deductible does not violate this section.

Example 5. (i) *Facts*. In conjunction with an annual open enrollment period, a group health plan provides a form for participants to certify that they have not used tobacco products in the preceding twelve months. Participants who do not provide the certification are assessed a surcharge that is 20 percent of the cost of employee-only coverage. However, all plan materials describing the terms of the wellness program include the following statement: ''If it is unreasonably difficult due to a health factor for you to meet the requirements under this program (or if it is medically inadvisable for you to attempt to meet the requirements of this program), we will make available a reasonable alternative standard for you to avoid this surcharge.'' It is unreasonably difficult for Individual *F* to stop smoking cigarettes due to an addiction to nicotine (a medical

condition). The plan accommodates *F* by requiring *F* to participate in a smoking cessation program to avoid the surcharge. *F* can avoid the surcharge for as long as *F* participates in the program, regardless of whether *F* stops smoking (as long as *F* continues to be addicted to nicotine).

(ii) *Conclusion*. In this *Example 5*, the premium surcharge is permissible as a wellness program because it satisfies the five requirements of paragraph (f)(2) of this section. First, the program complies with the limits on rewards under a program. Second, it is reasonably designed to promote health or prevent disease. Third, individuals eligible for the program are given the opportunity to qualify for the reward at least once per year. Fourth, the reward under the program is available to all similarly situated individuals because it accommodates individuals for whom it is unreasonably difficult due to a medical condition (or for whom it is medically inadvisable to attempt) to quit using tobacco products by providing a reasonable alternative standard. Fifth, the plan discloses in all materials describing the terms of the program the availability of a reasonable alternative standard. Thus, the premium surcharge does not violate this section.

Example 6. (i) *Facts*. Same facts as *Example 5*, except the plan accommodates *F* by requiring *F* to view, over a period of 12 months, a 12-hour video series on health problems associated with tobacco use. *F* can avoid the surcharge by complying with this requirement.

(ii) *Conclusion*. In this *Example 6*, the requirement to watch the series of video tapes is a reasonable alternative method for avoiding the surcharge.

(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 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 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 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 provision of ERISA (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 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, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) *Applicability dates*. This section applies for plan years beginning on or after July 1, 2007.

[T.D. 9298, 71 FR 75030, Dec. 13, 2006; 72 FR 7929, Feb. 22, 2007, as amended by T.D. 9464, 74 FR 51678, Oct. 7, 2009]

§ 54.9802–2 Special rules for certain church plans.

(a) *Exception for certain church plans*—(1) *Church plans in general*. A church plan described in paragraph (b) of this section is not treated as failing to meet the requirements of section 9802 or § 54.9802–1 solely because the plan requires evidence of good health for coverage of individuals under plan provisions described in paragraph (b)(2) or (3) of this section.

(2) *Health insurance issuers*. See sections 2702 and 2721(b)(1)(B) of the Public Health Service Act (42 U.S.C. 300gg–2 and 300gg–21(b)(1)(B)) and 45 CFR 146.121, which require health insurance issuers providing health insurance coverage under a church plan that is a group health plan to comply with nondiscrimination requirements similar to those that church plans are required to comply with under section 9802 and § 54.9802–1 except that those nondiscrimination requirements do not include an exception for health insurance issuers comparable to the exception for church plans under section 9802(c) and this section.

(b) *Church plans to which this section applies*—(1) *Church plans with certain coverage provisions in effect on July 15, 1997*. This section applies to any church plan (as defined in section 414(e)) for a plan year if, on July 15, 1997 and at all times thereafter before the beginning of the plan year, the plan contains either the provisions described in paragraph (b)(2) of this section or the provisions described in paragraph (b)(3) of this section.

(2) *Plan provisions applicable to individuals employed by employers of 10 or*

fewer employees and self-employed individuals. (i) A plan contains the provisions described in this paragraph (b)(2) if it requires evidence of good health of both—

(A) Any employee of an employer of 10 or fewer employees (determined without regard to section 414(e)(3)(C), under which a church or convention or association of churches is treated as the employer); and

(B) Any self-employed individual.

(ii) A plan does not contain the provisions described in this paragraph (b)(2) if the plan contains only one of the provisions described in this paragraph (b)(2). Thus, for example, a plan that requires evidence of good health of any self-employed individual, but not of any employee of an employer with 10 or fewer employees, does not contain the provisions described in this paragraph (b)(2). Moreover, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer of fewer than 10 (or greater than 10) employees. Thus, for example, a plan does not contain the provision described in paragraph (b)(2)(i)(A) of this section if the plan requires evidence of good health of any employee of an employer with five or fewer employees.

(3) *Plan provisions applicable to individuals who enroll after the first 90 days of initial eligibility*. (i) A plan contains the provisions described in this paragraph (b)(3) if it requires evidence of good health of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) A plan does not contain the provisions described in this paragraph (b)(3) if it provides for a longer (or shorter) period than 90 days. Thus, for example, a plan requiring evidence of good health of any individual who enrolls after the first 120 days of initial eligibility under the plan does not contain the provisions described in this paragraph (b)(3).

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

Example 1. (i) *Facts*. A church organization maintains two church plans for entities affiliated with the church. One plan is a group health plan that provides health coverage to all employees (including ministers and lay workers) of any affiliated church entity that has more than 10 employees. The other plan is Plan *O*, which is a group health plan that is not funded through insurance coverage and that provides health coverage to any employee (including ministers and lay workers) of any affiliated church entity that has 10 or fewer employees and any self-employed individual affiliated with the church (including a self-employed minister of the church). Plan *O* requires evidence of good health in order for any individual of a church entity that has 10 or fewer employees to be covered and in order for any self-employed individual to be covered. On July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *O* has contained all the preceding provisions.

(ii) *Conclusion*. In this *Example 1*, because Plan *O* contains the plan provisions described in paragraph (b)(2) of this section and because those provisions were in the plan on July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *O* will not be treated as failing to meet the requirements of section 9802 or § 54.9802–1 for the plan year solely because the plan requires evidence of good health for coverage of the individuals described in those plan provisions.

Example 2. (i) *Facts*. A church organization maintains Plan *P*, which is a church plan that is not funded through insurance coverage and that is a group health plan providing health coverage to individuals employed by entities affiliated with the church and self-employed individuals affiliated with the church (such as ministers). On July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *P* has required evidence of good health for coverage of any individual who enrolls after the first 90 days of initial eligibility under the plan.

(ii) *Conclusion*. In this *Example 2*, because Plan P contains the plan provisions described in paragraph (b)(3) of this section and because those provisions were in the plan on July 15, 1997 and at all times thereafter before the beginning of the plan year, Plan *P* will not be treated as failing to meet the requirements of section 9802 or § 54.9802–1 for the plan year solely because the plan requires evidence of good health for coverage of individuals enrolling after the first 90 days of initial eligibility under the plan.

(d) *Applicability date*. This section is applicable to plan years beginning on or after July 1, 2007.

[T.D. 9299, 71 FR 75056, Dec. 13, 2006]

§ 54.9802–3T Additional requirements prohibiting discrimination based on genetic information (temporary).

(a) *Definitions*. Unless otherwise provided, the definitions in this paragraph (a) govern in applying the provisions of this section.

(1) *Collect* means, with respect to information, to request, require, or purchase such information.

(2) *Family member* means, with respect to an individual —

(i) A dependent (as defined for purposes of § 54.9801–2) of the individual; or

(ii) Any other person who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual or of a dependent of the individual. Relatives by affinity (such as by marriage or adoption) are treated the same as relatives by consanguinity (that is, relatives who share a common biological ancestor). In determining the degree of the relationship, relatives by less than full consanguinity (such as half-siblings, who share only one parent) are treated the same as relatives by full consanguinity (such as siblings who share both parents).

(A) First-degree relatives include parents, spouses, siblings, and children.

(B) Second-degree relatives include grandparents, grandchildren, aunts, uncles, nephews, and nieces.

(C) Third-degree relatives include great-grandparents, great-grandchildren, great aunts, great uncles, and first cousins.

(D) Fourth-degree relatives include great-great grandparents, great-great grandchildren, and children of first cousins.

(3) *Genetic information* means—

(i) Subject to paragraphs (a)(3)(ii) and (a)(3)(iii) of this section, with respect to an individual, information about—

(A) The individual's genetic tests (as defined in paragraph (a)(5) of this section);

(B) The genetic tests of family members of the individual;

(C) The manifestation (as defined in paragraph (a)(6) of this section) of a disease or disorder in family members of the individual; or

(D) Any request for, or receipt of, genetic services (as defined in paragraph (a)(4) of this section), or participation in clinical research which includes genetic services, by the individual or any family member of the individual.

(ii) The term *genetic information* does not include information about the sex or age of any individual.

(iii) The term *genetic information* includes—

(A) With respect to a pregnant woman (or a family member of the pregnant woman), genetic information of any fetus carried by the pregnant woman; and

(B) With respect to an individual (or a family member of the individual) who is utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

(4) *Genetic services* means—

(i) A genetic test, as defined in paragraph (a)(5) of this section;

(ii) Genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(iii) Genetic education.

(5)(i) *Genetic test* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. However, a genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition. Accordingly, a test to determine whether an individual has a BRCA1 or BRCA2 variant is a genetic test. Similarly, a test to determine whether an individual has a genetic variant associated with hereditary nonpolyposis colorectal cancer is a genetic test. However, an HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test.

(ii) The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) *Facts*. Individual A is a newborn covered under a group health plan. A undergoes a phenylketonuria (PKU) screening, which measures the concentration of a metabolite, phenylalanine, in A's blood. In PKU, a mutation occurs in the phenylalanine hydroxylase (PAH) gene which contains instructions for making the enzyme needed to break down the amino acid phenylalanine. Individuals with the mutation, who have a deficiency in the enzyme to

break down phenylalanine, have high concentrations of phenylalanine.

(ii) *Conclusion.* In this *Example,* the PKU screening is a genetic test with respect to A because the screening is an analysis of metabolites that detects a genetic mutation.

(6)(i) *Manifestation* or *manifested* means, with respect to a disease, disorder, or pathological condition, that an individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved. For purposes of this section, a disease, disorder, or pathological condition is not manifested if a diagnosis is based principally on genetic information.

(ii) The rules of this paragraph (a)(6) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A has a family medical history of diabetes. A begins to experience excessive sweating, thirst, and fatigue. A's physician examines A and orders blood glucose testing (which is not a genetic test). Based on the physician's examination, A's symptoms, and test results that show elevated levels of blood glucose, A's physician diagnoses A as having adult onset diabetes mellitus (Type 2 diabetes).

(ii) *Conclusion.* In this *Example 1,* A has been diagnosed by a health care professional with appropriate training and expertise in the field of medicine involved. The diagnosis is not based principally on genetic information. Thus, Type 2 diabetes is manifested with respect to A.

Example 2. (i) *Facts.* Individual B has several family members with colon cancer. One of them underwent genetic testing which detected a mutation in the MSH2 gene associated with hereditary nonpolyposis colorectal cancer (HNPCC). B's physician, a health care professional with appropriate training and expertise in the field of medicine involved, recommends that B undergo a targeted genetic test to look for the specific mutation found in B's relative to determine if B has an elevated risk for cancer. The genetic test with respect to B showed that B also carries the mutation and is at increased risk to develop colorectal and other cancers associated with HNPCC. B has a colonoscopy which indicates no signs of disease, and B has no symptoms.

(ii) *Conclusion.* In this *Example 2,* because B has no signs or symptoms of colorectal cancer, B has not been and could not reasonably be diagnosed with HNPCC. Thus, HNPCC is not manifested with respect to B.

Example 3. (i) *Facts.* Same facts as *Example 2,* except that B's colonoscopy and subsequent tests indicate the presence of HNPCC. Based on the colonoscopy and subsequent test results, B's physician makes a diagnosis of HNPCC.

(ii) Conclusion. In this *Example 3,* HNPCC is manifested with respect to B because a health care professional with appropriate training and expertise in the field of medicine involved has made a diagnosis that is not based principally on genetic information.

Example 4. (i) *Facts.* Individual C has a family member that has been diagnosed with Huntington's Disease. A genetic test indicates that C has the Huntington's Disease gene variant. At age 42, C begins suffering from occasional moodiness and disorientation, symptoms which are associated with Huntington's Disease. C is examined by a neurologist (a physician with appropriate training and expertise for diagnosing Huntington's Disease). The examination includes a clinical neurological exam. The results of the examination do not support a diagnosis of Huntington's Disease.

(ii) *Conclusion.* In this *Example 4,* C is not and could not reasonably be diagnosed with Huntington's Disease by a health care professional with appropriate training and expertise. Therefore, Huntington's Disease is not manifested with respect to C.

Example 5. (i) *Facts.* Same facts as *Example 4,* except that C exhibits additional neurological and behavioral symptoms, and the results of the examination support a diagnosis of Huntington's Disease with respect to C.

(ii) *Conclusion.* In this *Example 5,* C could reasonably be diagnosed with Huntington's Disease by a health care professional with appropriate training and expertise. Therefore, Huntington's Disease is manifested with respect to C.

(7) *Underwriting purposes* has the meaning given in paragraph (d)(1) of this section.

(b) *No group-based discrimination based on genetic information*—(1) *In general.* For purposes of this section, a group health plan must not adjust premium or contribution amounts for any employer, or any group of similarly situated individuals under the plan, on the basis of genetic information. For this purpose, ''similarly situated individuals'' are those described in § 54.9802–1(d).

(2) *Rule of construction.* Nothing in paragraph (b)(1) of this section (or in paragraph (d)(1) or (d)(2) of this section) limits the ability of a group health plan to increase the premium for an employer or for a group of similarly situated individuals under the plan based on the manifestation of a

disease or disorder of an individual who is enrolled in the plan. In such a case, however, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members to further increase the premium for an employer or a group of similarly situated individuals under the plan.

(3) *Examples*. The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts*. An employer sponsors a group health plan that provides coverage through 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 and other health status information of the individuals, including genetic information. The issuer finds that three individuals covered under the plan had unusually high claims experience. In addition, the issuer finds that the genetic information of two other individuals indicates the individuals have a higher probability of developing certain illnesses although the illnesses are not manifested at this time. The issuer quotes the plan a higher per-participant rate because of both the genetic information and the higher claims experience.

(ii) *Conclusion*. See *Example 1* in 29 CFR 2590.702–1(b)(3) or 45 CFR 146.122(b)(3) for a conclusion that the issuer violates the provisions of 29 CFR 2590.702–1(b) or 45 CFR 146.122(b) similar to the requirements of this paragraph (b) because the issuer adjusts the premium based on genetic information. However, if the adjustment related solely to claims experience, the adjustment would not violate the requirements of 29 CFR 2590.702–1 or 45 CFR 146.122 similar to the requirements of this section (nor would it violate the requirements of paragraph (c) of 29 CFR 2590.702 or 45 CFR 146.121 similar to the requirements of paragraph (c) of § 54.9802–1, which prohibits discrimination in individual premiums or contributions based on a health factor but permits increases in the group rate based on a health factor).

Example 2. (i) *Facts*. An employer sponsors a group health plan that provides coverage through 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 and other health status information of the individuals, including genetic information. The issuer finds that Employee A has made claims for treatment of polycystic kidney disease. A also has two dependent children covered under the plan. The issuer quotes the plan a higher per-participant rate because of both A's claims experience and the family medical history of A's children (that is, the fact that A has the disease).

(ii) *Conclusion*. See *Example 2* in 29 CFR 2590.702–1(b)(3) or 45 CFR 146.122(b)(3) for a conclusion that the issuer violates the provisions of 29 CFR 2590.702–1(b) or 45 CFR 146.122(b) similar to the requirements of this paragraph (b) because, by taking the likelihood that A's children may develop polycystic kidney disease into account in computing the rate for the plan, the issuer adjusts the premium based on genetic information relating to a condition that has not been manifested in A's children. However, the issuer does not violate the requirements of 29 CFR 2590.702–1(b) or 45 CFR 146.122(b) similar to the requirements of this paragraph (b) by increasing the premium based on A's claims experience.

(c) *Limitation on requesting or requiring genetic testing*—(1) *General rule*. Except as otherwise provided in this paragraph (c), a group health plan must not request or require an individual or a family member of the individual to undergo a genetic test.

(2) *Health care professional may recommend a genetic test*. Nothing in paragraph (c)(1) of this section limits the authority of a health care professional who is providing health care services to an individual to request that the individual undergo a genetic test.

(3) *Examples*. The rules of paragraphs (c)(1) and (c)(2) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. Individual A goes to a physician for a routine physical examination. The physician reviews A's family medical history and A informs the physician that A's mother has been diagnosed with Huntington's Disease. The physician advises A that Huntington's Disease is hereditary and recommends that A undergo a genetic test.

(ii) *Conclusion*. In this *Example 1*, the physician is a health care professional who is providing health care services to A. Therefore, the physician's recommendation that A undergo the genetic test does not violate this paragraph (c).

Example 2. (i) *Facts*. Individual B is covered by a health maintenance organization (HMO). *B* is a child being treated for leukemia. B's physician, who is employed by the HMO, is considering a treatment plan that includes six-mercaptopurine, a drug for treating leukemia in most children. However, the drug could be fatal if taken by a small percentage of children with a particular gene variant. B's physician recommends that B undergo a genetic test to detect this variant before proceeding with this course of treatment.

(ii) *Conclusion*. In this *Example 2*, even though the physician is employed by the HMO, the physician is nonetheless a health care professional who is providing health care services to B. Therefore, the physician's recommendation that B undergo the genetic test does not violate this paragraph (c).

(4) *Determination regarding payment*—(i) *In general*. As provided in this paragraph (c)(4), nothing in paragraph (c)(1) of this section precludes a plan from obtaining and using the results of a genetic test in making a determination regarding payment. For this purpose, ''payment'' has the meaning given such term in 45 CFR 164.501 of the privacy regulations issued under the Health Insurance Portability and Accountability Act. Thus, if a plan conditions payment for an item or service based on its medical appropriateness and the medical appropriateness of the item or service depends on the genetic makeup of a patient, then the plan is permitted to condition payment for the item or service on the outcome of a genetic test. The plan may also refuse payment if the patient does not undergo the genetic test.

(ii) *Limitation*. A plan is permitted to request only the minimum amount of information necessary to make a determination regarding payment. The minimum amount of information necessary is determined in accordance with the minimum necessary standard in 45 CFR 164.502(b) of the privacy regulations issued under the Health Insurance Portability and Accountability Act.

(iii) *Examples*. *See* paragraph (e) of this section for examples illustrating the rules of this paragraph (c)(4), as well as other provisions of this section.

(5) *Research exception*. Notwithstanding paragraph (c)(1) of this section, a plan may request, but not require, that a participant or beneficiary undergo a genetic test if all of the conditions of this paragraph (c)(5) are met:

(i) *Research in accordance with Federal regulations and applicable State or local law or regulations*. The plan makes the request pursuant to research, as defined in 45 CFR 46.102(d), that complies with 45 CFR Part 46 or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(ii) *Written request for participation in research*. The plan makes the request in writing, and the request clearly indicates to each participant or beneficiary (or, in the case of a minor child, to the legal guardian of the beneficiary) that—

(A) Compliance with the request is voluntary; and

(B) Noncompliance will have no effect on eligibility for benefits (as described in § 54.9802–1(b)(1)) or premium or contribution amounts.

(iii) *Prohibition on underwriting*. No genetic information collected or acquired under this paragraph (c)(5) can be used for underwriting purposes (as described in paragraph (d)(1) of this section).

(iv) *Notice to Federal agencies*. The plan completes a copy of the ''Notice of Research Exception under the Genetic Information Nondiscrimination Act'' authorized by the Secretary and provides the notice to the address specified in the instructions thereto.

(d) *Prohibitions on collection of genetic information*—(1) *For underwriting purposes*—(i) *General rule*. A group health plan must not collect (as defined in paragraph (a)(1) of this section) genetic information for underwriting purposes. *See* paragraph (e) of this section for examples illustrating the rules of this paragraph (d)(1), as well as other provisions of this section.

(ii) *Underwriting purposes defined*. Subject to paragraph (d)(1)(iii) of this section, *underwriting purposes* means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage as described in § 54.9802–1(b)(1)(ii) (including changes in deductibles or other cost-sharing mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program);

(B) The computation of premium or contribution amounts under the plan or coverage (including discounts, rebates, payments in kind, or other premium differential mechanisms in return for activities such as completing a

health risk assessment or participating in a wellness program);

(C) The application of any preexisting condition exclusion under the plan or coverage; and

(D) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(iii) *Medical appropriateness.* If an individual seeks a benefit under a group health plan, the plan may limit or exclude the benefit based on whether the benefit is medically appropriate, and the determination of whether the benefit is medically appropriate is not within the meaning of underwriting purposes. Accordingly, if an individual seeks a benefit under the plan and the plan conditions the benefit based on its medical appropriateness and the medical appropriateness of the benefit depends on genetic information of the individual, then the plan is permitted to condition the benefit on the genetic information. A plan is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness. The plan may deny the benefit if the patient does not provide the genetic information required to determine medical appropriateness. If an individual is not seeking a benefit, the medical appropriateness exception of this paragraph (d)(1)(iii) to the definition of underwriting purposes does not apply. *See* paragraph (e) of this section for examples illustrating the medical appropriateness provisions of this paragraph (d)(1)(iii), as well as other provisions of this section.

(2) *Prior to or in connection with enrollment*—(i) *In general.* A group health plan must not collect genetic information with respect to any individual prior to that individual's effective date of coverage under that plan, nor in connection with the rules for eligibility (as defined in § 54.9802–1(b)(1)(ii)) that apply to that individual. Whether or not an individual's information is collected prior to that individual's effective date of coverage is determined at the time of collection.

(ii) *Incidental collection exception*—(A) *In general.* If a group health plan obtains genetic information incidental to the collection of other information concerning any individual, the collection is not a violation of this paragraph (d)(2), as long as the collection is not for underwriting purposes in violation of paragraph (d)(1) of this section.

(B) *Limitation.* The incidental collection exception of this paragraph (d)(2)(ii) does not apply in connection with any collection where it is reasonable to anticipate that health information will be received, unless the collection explicitly states that genetic information should not be provided.

(3) *Examples.* The rules of this paragraph (d) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides a premium reduction to enrollees who complete a health risk assessment. The health risk assessment is requested to be completed after enrollment. Whether or not it is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The health risk assessment includes questions about the individual's family medical history.

(ii) *Conclusion.* In this *Example 1,* the health risk assessment includes a request for genetic information (that is, the individual's family medical history). Because completing the health risk assessment results in a premium reduction, the request for genetic information is for underwriting purposes. Consequently, the request violates the prohibition on the collection of genetic information in paragraph (d)(1) of this section.

Example 2. (i) *Facts.* The same facts as *Example 1,* except there is no premium reduction or any other reward for completing the health risk assessment.

(ii) *Conclusion.* In this *Example 2,* the request is not for underwriting purposes, nor is it prior to or in connection with enrollment. Therefore, it does not violate the prohibition on the collection of genetic information in this paragraph (d).

Example 3. (i) *Facts.* A group health plan requests that enrollees complete a health risk assessment prior to enrollment, and includes questions about the individual's family medical history. There is no reward or penalty for completing the health risk assessment.

(ii) *Conclusion.* In this *Example 3,* because the health risk assessment includes a request for genetic information (that is, the individual's family medical history), and requests the information prior to enrollment, the request violates the prohibition on the collection of genetic information in paragraph (d)(2) of this section. Moreover, because it is a request for genetic information,

it is not an incidental collection under paragraph (d)(2)(ii) of this section.

Example 4. (i) *Facts.* The facts are the same as in *Example 1,* except there is no premium reduction or any other reward given for completion of the health risk assessment. However, certain people completing the health risk assessment may become eligible for additional benefits under the plan by being enrolled in a disease management program based on their answers to questions about family medical history. Other people may become eligible for the disease management program based solely on their answers to questions about their individual medical history.

(ii) *Conclusion.* In this *Example 4,* the request for information about an individual's family medical history could result in the individual being eligible for benefits for which the individual would not otherwise be eligible. Therefore, the questions about family medical history on the health risk assessment are a request for genetic information for underwriting purposes and are prohibited under this paragraph (d). Although the plan conditions eligibility for the disease management program based on determinations of medical appropriateness, the exception for determinations of medical appropriateness does not apply because the individual is not seeking benefits.

Example 5. (i) *Facts.* A group health plan requests enrollees to complete two distinct health risk assessments (HRAs) after and unrelated to enrollment. The first HRA instructs the individual to answer only for the individual and not for the individual's family. The first HRA does not ask about any genetic tests the individual has undergone or any genetic services the individual has received. The plan offers a reward for completing the first HRA. The second HRA asks about family medical history and the results of genetic tests the individual has undergone. The plan offers no reward for completing the second HRA and the instructions make clear that completion of the second HRA is wholly voluntary and will not affect the reward given for completion of the first HRA.

(ii) *Conclusion.* In this *Example 5,* no genetic information is collected in connection with the first HRA, which offers a reward, and no benefits or other rewards are conditioned on the request for genetic information in the second HRA. Consequently, the request for genetic information in the second HRA is not for underwriting purposes, and the two HRAs do not violate the prohibition on the collection of genetic information in this paragraph (d).

Example 6. (i) *Facts.* A group health plan waives its annual deductible for enrollees who complete an HRA. The HRA is requested to be completed after enrollment. Whether or not the HRA is completed or what responses are given on it has no effect on an individual's enrollment status, or on the enrollment status of members of the individual's family. The HRA does not include any direct questions about the individual's genetic information (including family medical history). However, the last question reads, ''Is there anything else relevant to your health that you would like us to know or discuss with you?''

(ii) *Conclusion.* In this *Example 6,* the plan's request for medical information does not explicitly state that genetic information should not be provided. Therefore, any genetic information collected in response to the question is not within the incidental collection exception and is prohibited under this paragraph (d).

Example 7. (i) *Facts.* Same facts as *Example 6,* except that the last question goes on to state, ''In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.''

(ii) *Conclusion.* In this *Example 7,* the plan's request for medical information explicitly states that genetic information should not be provided. Therefore, any genetic information collected in response to the question is within the incidental collection exception. However, the plan may not use any genetic information it obtains incidentally for underwriting purposes.

Example 8. (i) *Facts.* Issuer M acquires Issuer N. M requests N's records, stating that N should not provide genetic information and should review the records to excise any genetic information. N assembles the data requested by M and, although N reviews it to delete genetic information, the data from a specific region included some individuals' family medical history. Consequently, M receives genetic information about some of N's covered individuals.

(ii) *Conclusion.* In this *Example 8,* M's request for health information explicitly stated that genetic information should not be provided. *See Example 8* in 29 CFR 2590.702–1(d)(3) or 45 CFR 146.122(d)(3) for a conclusion that the collection of genetic information was within the incidental collection exception of 29 CFR 2590.702–1(d)(2)(ii) or 45 CFR 146.122(d)(ii) similar to the incidental exception of paragraph (d)(2)(ii) of this section. *See Example 8* in 29 CFR 2590.702–1(d)(3) or 45 CFR 146.122(d)(3) also for a caveat that M may not use the genetic information it obtained incidentally for underwriting purposes.

(e) *Examples regarding determinations of medical appropriateness.* The application of the rules of paragraphs (c) and

(d) of this section to plan determinations of medical appropriateness is illustrated by the following examples:

Example 1. (i) *Facts.* Individual A's group health plan covers genetic testing for celiac disease for individuals who have family members with this condition. After A's son is diagnosed with celiac disease, A undergoes a genetic test and promptly submits a claim for the test to A's issuer for reimbursement. The issuer asks A to provide the results of the genetic test before the claim is paid.

(ii) *Conclusion.* See *Example 1* in 29 CFR 2590.702–1(e) or 45 CFR 146.122(e) for a conclusion under the rules of paragraph (c)(4) of 29 CFR 2590.702–1 or 45 CFR 146.122 similar to the rules of paragraph (c)(4) of this section that the issuer is permitted to request only the minimum amount of information necessary to make a decision regarding payment. Because the results of the test are not necessary for the issuer to make a decision regarding the payment of A's claim, the conclusion in *Example 1* in 29 CFR 2590.702–1(e) or 45 CFR 146.122(e) concludes that the issuer's request for the results of the genetic test violates paragraph (c) of 29 CFR 2590.702–1 or 45 CFR 146.122 similar to paragraph (c) of this section.

Example 2. (i) *Facts.* Individual B's group health plan covers a yearly mammogram for participants and beneficiaries starting at age 40, or at age 30 for those with increased risk for breast cancer, including individuals with BRCA1 or BRCA2 gene mutations. B is 33 years old and has the BRCA2 mutation. B undergoes a mammogram and promptly submits a claim to B's plan for reimbursement. Following an established policy, the plan asks B for evidence of increased risk of breast cancer, such as the results of a genetic test or a family history of breast cancer, before the claim for the mammogram is paid. This policy is applied uniformly to all similarly situated individuals and is not directed at individuals based on any genetic information.

(ii) *Conclusion.* In this *Example 2,* the plan does not violate paragraphs (c) or (d) of this section. Under paragraph (c), the plan is permitted to request and use the results of a genetic test to make a determination regarding payment, provided the plan requests only the minimum amount of information necessary. Because the medical appropriateness of the mammogram depends on the genetic makeup of the patient, the minimum amount of information necessary includes the results of the genetic test. Similarly, the plan does not violate paragraph (d) of this section because the plan is permitted to request genetic information in making a determination regarding the medical appropriateness of a claim if the genetic information is necessary to make the determination (and if the genetic information is not used for underwriting purposes).

Example 3. (i) *Facts.* Individual C was previously diagnosed with and treated for breast cancer, which is currently in remission. In accordance with the recommendation of C's physician, C has been taking a regular dose of tamoxifen to help prevent a recurrence. C's group health plan adopts a new policy requiring patients taking tamoxifen to undergo a genetic test to ensure that tamoxifen is medically appropriate for their genetic makeup. In accordance with, at the time, the latest scientific research, tamoxifen is not helpful in up to 7 percent of breast cancer patients, those with certain variations of the gene for making the CYP_2D6 enzyme. If a patient has a gene variant making tamoxifen not medically appropriate, the plan does not pay for the tamoxifen prescription.

(ii) *Conclusion.* In this *Example 3,* the plan does not violate paragraph (c) of this section if it conditions future payments for the tamoxifen prescription on C's undergoing a genetic test to determine what genetic markers C has for making the CYP_2D6 enzyme. Nor does the plan violate paragraph (c) of this section if the plan refuses future payment if the results of the genetic test indicate that tamoxifen is not medically appropriate for C.

Example 4. (i) *Facts.* A group health plan offers a diabetes disease management program to all similarly situated individuals for whom it is medically appropriate based on whether the individuals have or are at risk for diabetes. The program provides enhanced benefits related only to diabetes for individuals who qualify for the program. The plan sends out a notice to all participants that describes the diabetes disease management program and explains the terms for eligibility. Individuals interested in enrolling in the program are advised to contact the plan to demonstrate that they have diabetes or that they are at risk for diabetes. For individuals who do not currently have diabetes, genetic information may be used to demonstrate that an individual is at risk.

(ii) *Conclusion.* In this *Example 4,* the plan may condition benefits under the disease management program upon a showing by an individual that the individual is at risk for diabetes, even if such showing may involve genetic information, provided that the plan requests genetic information only when necessary to make a determination regarding whether the disease management program is medically appropriate for the individual and only requests the minimum amount of information necessary to make that determination.

Example 5. (i) *Facts.* Same facts as *Example 4,* except that the plan includes a questionnaire that asks about the occurrence of diabetes in members of the individual's family

as part of the notice describing the disease management program.

(ii) *Conclusion*. In this *Example 5*, the plan violates the requirements of paragraph (d)(1) of this section because the requests for genetic information are not limited to those situations in which it is necessary to make a determination regarding whether the disease management program is medically appropriate for the individuals.

Example 6. (i) *Facts*. Same facts as *Example 4*, except the disease management program provides an enhanced benefit in the form of a lower annual deductible to individuals under the program; the lower deductible applies with respect to all medical expenses incurred by the individual. Thus, whether or not a claim relates to diabetes, the individual is provided with a lower deductible based on the individual providing the plan with genetic information.

(ii) *Conclusion*. In this *Example 6*, because the enhanced benefits include benefits not related to the determination of medical appropriateness, making available the enhanced benefits is within the meaning of underwriting purposes. Accordingly, the plan may not request or require genetic information (including family history information) in determining eligibility for enhanced benefits under the program because such a request would be for underwriting purposes and would violate paragraph (d)(1) of this section.

(f) *Effective/applicability date*. This section applies for plan years beginning on or after December 7, 2009.

(g) *Expiration date*. This section expires on or before October 1, 2012.

[T.D. 9464, 74 FR 51678, Oct. 7, 2009]

§ 54.9811–1 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 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) *Facts*. 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) *Conclusion*. 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) *Facts*. 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) *Conclusion*. 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) *Facts*. 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) *Conclusion*. 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 may not require that a physician or other health care provider obtain authorization from the plan, or from a health insurance issuer offering health insurance coverage under the plan, for prescribing the hospital length of stay specified in 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) *Facts*. In the case of a delivery by cesarean 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) *Conclusion*. 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 cesarean 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. Therefore, a plan, hospital, managed care organization, or other issuer is not an attending provider.

(iv) *Example*. The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) *Facts*. 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 cesarean 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) *Conclusion*. 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 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) *Facts*. 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) *Conclusion*. 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) *Facts*. 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) *Conclusion*. 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 may not restrict the benefits for any portion of a hospital length of stay specified in 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) *Facts*. 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 cesarean 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) *Conclusion*. 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, the requirement to obtain precertification from the plan based on medical necessity for a hospital length of stay within the 96-hour period would also violate paragraph (a) of this section.

(3) *With respect to attending providers*. A group health plan 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 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 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 specified in 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) *Facts*. 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) *Conclusion*. 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) *Facts*. 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) *Conclusion*. 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 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) for rules relating to a disclosure requirement imposed under section 711(d) of ERISA (29 U.S.C. 1181) on certain group health plans that provide benefits for hospital lengths of stay in connection with childbirth.

(e) *Applicability in certain states*—(1) *Health insurance coverage*. The requirements of section 9811 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 cesarean section.

(ii) The state law requires the coverage to provide for maternity and pediatric care in accordance with guidelines that relate to care following childbirth 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 9811 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 9811 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 9811 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) *Preemption provisions under section 731(a) of ERISA*. See 29 CFR 2590.711(e)(3) for a rule providing that the preemption provisions contained in section 731(a)(1) of ERISA and 29 CFR 2590.731(a) do not supersede a state law if the state law is described in paragraph (e)(1) of 29 CFR 2590.711 (which is substantially similar to paragraph (e)(1) of this section).

(4) *Examples*. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts*. 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 cesarean section.

(ii) *Conclusion*. In this *Example 1*, the coverage is subject to state law, and the requirements of section 9811 and this section do not apply.

Example 2. (i) *Facts*. 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 and pediatric care in accordance with guidelines that relate to care following childbirth established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

(ii) *Conclusion*. 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 9811 and this section.

(f) *Effective/applicability date*. This section applies to group health plans for plan years beginning on or after January 1, 2009.

[T.D. 9427, 73 FR 62420, Oct. 20, 2008]

§ 54.9812–1T Parity in mental health and substance use disorder benefits (temporary).

(a) *Meaning of terms*. For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan for any coverage unit.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health or substance use disorder benefits. Any condition defined by the plan as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).

Mental health benefits means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

Substance use disorder benefits means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits

for treatment under a plan. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits*—(1) *General*—(i) *General parity requirement*. A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(6) of this section.

(ii) *Exception*. The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits*. If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits*. If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) *Examples*. The rules of paragraphs (b)(2) and (b)(3) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan has no annual limit on medical/surgical benefits and a $10,000 annual limit on mental health and substance use disorder benefits. To comply with the requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual dollar limit on mental health and substance use disorder benefits;

(B) Replacing the plan's annual dollar limit on mental health and substance use disorder benefits with a $500,000 annual limit on all benefits (including medical/surgical and mental health and substance use disorder benefits); and

(C) Replacing the plan's annual dollar limit on mental health and substance use disorder benefits with a $250,000 annual limit on medical/surgical benefits and a $250,000 annual limit on mental health and substance use disorder benefits.

(ii) *Conclusion*. In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this paragraph (b).

Example 2. (i) *Facts*. A plan has a $100,000 annual limit on medical/surgical inpatient benefits and a $50,000 annual limit on medical/surgical outpatient benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Imposing a $150,000 annual limit on mental health and substance use disorder benefits; and

(B) Imposing a $100,000 annual limit on mental health and substance use disorder inpatient benefits and a $50,000 annual limit on mental health and substance use disorder outpatient benefits.

(ii) *Conclusion*. In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section.

(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 an aggregate lifetime or annual dollar 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 dollar limits). Any reasonable method may be used to determine whether the dollar amount 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 (b)(3) of this section*—(i) *In general.* A group health plan that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either—

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder 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 dollar 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 dollar 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) *Facts.* 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 dollar limit on any other category of medical/surgical benefits. The plan determines that 40 percent 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 percent of payments for medical/surgical benefits.

(ii) *Conclusion.* In this *Example,* the plan is not described in paragraph (b)(3) of this section because there is not one annual dollar 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 dollar limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual dollar limit on mental health or substance use disorder benefits, or to include an annual dollar limit on mental health or substance use disorder benefits that is not less than the weighted average of the annual dollar limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual dollar limit that can be applied to mental health or substance use disorder benefits is $640,000 (40% × $100,000 + 60% × $1,000,000 = $640,000).

(c) *Parity requirements with respect to financial requirements and treatment limitations*—(1) *Clarification of terms*—(i) *Classification of benefits.* When reference is made in this paragraph (c) to a classification of benefits, the term ''classification'' means a classification as described in paragraph (c)(2)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day

and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation.* When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include $15 and $20; different levels of a deductible include $250 and $500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) *Coverage unit.* When reference is made in this paragraph (c) to a coverage unit, coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

(2) *General parity requirement*—(i) *General rule.* A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (c)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (c)(3) of this section; the application of the rules of this paragraph (c)(2) to nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) *Classifications of benefits used for applying rules*—(A) *In general.* If a plan provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (c) apply separately with respect to that classification for all financial requirements or treatment limitations. The following classifications of benefits are the only classifications used in applying the rules of this paragraph (c):

(*1*) *Inpatient, in-network.* Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan.

(*2*) *Inpatient, out-of-network.* Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan. This classification includes inpatient benefits under a plan that has no network of providers.

(*3*) *Outpatient, in-network.* Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan.

(*4*) *Outpatient, out-of-network.* Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan. This classification includes outpatient benefits under a plan that has no network of providers.

(*5*) *Emergency care.* Benefits for emergency care.

(*6*) *Prescription drugs.* Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) *Application to out-of-network providers.* See paragraph (c)(2)(ii)(A) of this section, under which a plan that provides mental health or substance

use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) *Examples*. The rules of this paragraph (c)(2)(ii) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) *Facts*. A group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a $500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 1*, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the rules of this paragraph (c) apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2. (i) *Facts*. A plan imposes a $500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 2*, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance across all benefits.

Example 3. (i) *Facts*. Same facts as *Example 2*, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 3*, because the plan imposes separate financial requirements based on classifications, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance separately for—

(A) Benefits in the emergency classification; and

(B) All other benefits.

Example 4. (i) *Facts*. Same facts as *Example 2*, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) *Conclusion*. In this *Example 4*, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the rules of this paragraph (c) apply with respect to the deductible and coinsurance separately for—

(A) Inpatient, out-of-network benefits; and

(B) All other benefits.

(3) *Financial requirements and quantitative treatment limitations*—(i) *Determining ''substantially all'' and ''predominant''*—(A) *Substantially all*. For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) *Predominant*—*(1)* If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification

subject to the financial requirement or quantitative treatment limitation.

(*2*) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) *Portion based on plan payments.* For purposes of this paragraph (c), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification 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 financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements.* For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes.

(E) *Determining the dollar amount of plan payments.* Subject to paragraph (c)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) *Application to different coverage units.* If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

(iii) *Special rule for multi-tiered prescription drug benefits.* If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(iv) *Examples.* The rules of paragraphs (c)(3)(i), (c)(3)(ii), and (c)(3)(iii) of this section are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

Example 1. (i) *Facts.* For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan

projects its payments for the upcoming year as follows:

Coinsurance rate.	0%	10%	15%	20%	30%	Total
Projected payments.	$200x	$100x	$450x	$100x	$150x	$1,000x
Percent of total plan costs.	20%	10%	45%	10%	15%	
Percent subject to coinsurance level.	N/A	12.5% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The plan projects plan costs of $800x to be subject to coinsurance ($100x + $450x + $100x + $150x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) *Conclusion*. In this *Example 1*, the two-thirds threshold of the substantially all standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) *Facts*. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount.	$0	$10	$15	$20	$50	Total
Projected payments.	$200x	$200x	$200x	$300x	$100x	$1,000x
Percent of total plan costs.	20%	20%	20%	30%	10%	
Percent subject to copayments.	N/A	25% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The plan projects plan costs of $800x to be subject to copayments ($200x + $200x + $300x + $100x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to a copayment.

(ii) *Conclusion*. In this *Example 2*, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the $10 copayment, 25 percent; for the $15 copayment, 25 percent; for the $20 copayment, 37.5 percent; and for the $50 copayment, 12.5 percent). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the $50 copayment and the $20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a copayment because they are exactly one-half ($300x + $100x = $400x; $400x/$800x = 50%). The combined projected payments for the three highest copayment levels—the $50 copayment, the $20 copayment, and the $15 copayment—are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($100x + $300x + $200x = $600x; $600x/$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the $15 copayment.

Example 3. (i) *Facts*. A plan imposes a $250 deductible on all medical/surgical benefits for self-only coverage and a $500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 3*, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) *Facts*. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as ''generic'', ''preferred brand name'', ''non-preferred brand name'', or ''specialty'' complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

Tier description	Tier 1	Tier 2	Tier 3	Tier 4
	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) *Conclusion*. In this *Example 4*, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

(v) *No separate cumulative financial requirements or cumulative quantitative treatment limitations*. (A) A group health plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

(B) The rules of this paragraph (c)(3)(v) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a combined annual $500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 1,* the combined annual deductible complies with the requirements of this paragraph (c)(3)(v).

Example 2. (i) *Facts.* A plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $250 deductible on all mental health and substance use disorder benefits.

(ii) *Conclusion.* In this *Example 2,* the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 3. (i) *Facts.* A plan imposes an annual $300 deductible on all medical/surgical benefits and a separate annual $100 deductible on all mental health or substance use disorder benefits.

(ii) *Conclusion.* In this *Example 3,* the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

Example 4. (i) *Facts.* A plan generally imposes a combined annual $500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, in-network	$1,800x	$2,000x	90
Inpatient, out-of-network	1,000x	1,000x	100
Outpatient, in-network	1,400x	2,000x	70
Outpatient, out-of-network	1,880x	2,000x	94
Emergency care	300x	500x	60

(ii) *Conclusion.* In this *Example 4,* the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the $500 deductible. Moreover, the $500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the $500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) *Nonquantitative treatment limitations*—(i) *General rule.* A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

(ii) *Illustrative list of nonquantitative treatment limitations.* Nonquantitative treatment limitations include—

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and

(F) Exclusions based on failure to complete a course of treatment.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and

mental health and substance use disorder benefits.

Example 1. (i) *Facts.* A group health plan limits benefits to treatment that is medically necessary. The plan requires concurrent review for inpatient, in-network mental health and substance use disorder benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits.

(ii) *Conclusion.* In this *Example 1,* the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical necessity—applies to both mental health and substance use disorder benefits and to medical/surgical benefits for inpatient, in-network services, the concurrent review process does not apply to medical/surgical benefits. The concurrent review process is not comparable to the retrospective review process. While such a difference might be permissible in certain individual cases based on recognized clinically appropriate standards of care, it is not permissible for distinguishing between all medical/surgical benefits and all mental health or substance use disorder benefits.

Example 2. (i) *Facts.* A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) *Conclusion.* In this *Example 2,* the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical necessity—is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, the penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 3. (i) *Facts.* A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition.

(ii) *Conclusion.* In this *Example 3,* the plan complies with the rules of this paragraph (c)(4) because the nonquantitative treatment limitation—medical appropriateness—is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 4. (i) *Facts.* A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion.* In this *Example 4,* the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 5. (i) *Facts.* An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical program.

(ii) *Conclusion.* In this *Example 5,* limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no

comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

(5) *Exemptions*. The rules of this paragraph (c) do not apply if a group health plan satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(d) *Availability of plan information*—(1) *Criteria for medical necessity determinations*. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request.

(2) *Reason for denial*. The reason for any denial under a group health plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator to the participant or beneficiary in accordance with this paragraph (d)(2).

(i) *Plans subject to ERISA*. If a plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 CFR 2560.503–1 for group health plans.

(ii) *Plans not subject to ERISA*. If a plan is not subject to ERISA, upon the request of a participant or beneficiary the reason for the claim denial must be provided within a reasonable time and in a reasonable manner. For this purpose, a plan that follows the requirements of 29 CFR 2560.503–1 for group health plans complies with the requirements of this paragraph (d)(2)(ii).

(e) *Applicability*—(1) *Group health plans*. The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide health care benefits by an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), any participant (or beneficiary) can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section (including the exemption provisions in paragraph (g) of this section) apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide health care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) *Health insurance issuers*. See 29 CFR 2590.712(e)(2) and 45 CFR 146.136(e)(2), under which a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits is subject to requirements similar to those applicable to group health plans under this section if the health insurance coverage is offered in connection with a group health plan subject to requirements under 29 CFR 2590.712 or 45 CFR 146.136 similar to those applicable to group health plans under this section.

(3) *Scope*. This section does not—

(i) Require a group health plan to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan for one or more mental health conditions or substance use disorders does not require the plan under this section to provide benefits for any other mental health condition or substance use disorder; or

(ii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan except as specifically provided in paragraphs (b) and (c) of this section.

(f) *Small employer exemption*—(1) *In general*. The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (f), 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 (or one in

the case of an employer residing in a state that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. See section 9831(a)(2) and § 54.9831–1(b), which provide that this section (and certain other sections) does not apply to any 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 (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 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.

(g) *Increased cost exemption* [Reserved]

(h) *Sale of nonparity health insurance coverage.* See 29 CFR 2590.712(h) and 45 CFR 146.136(h), under which a health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with requirements similar to those under paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from requirements similar to those under paragraph (b) or (c) of this section because the plan meets requirements under paragraph (f) or (g) of 29 CFR 2590.712 or 45 CFR 146.136 similar to those under paragraph (f) or (g) of this section.

(i) *Effective/applicability dates*—(1) *In general.* Except as provided in paragraph (i)(2) of this section, the requirements of this section are applicable for plan years beginning on or after July 1, 2010.

(2) *Special effective date for certain collectively-bargained plans.* For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan for plan years beginning before the later of either—

(i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or

(ii) July 1, 2010.

(j) *Expiration date.* This section expires on or before *January 29, 2013.*

[T.D. 9479, 75 FR 5431, Feb. 2, 2010]

§ 54.9815–1251T Preservation of right to maintain existing coverage (temporary).

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *Grandfathered health plan coverage. Grandfathered health plan coverage* means coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage.

(ii) *Changes in group health insurance coverage.* Subject to paragraphs (f) and (g)(2) of this section, if a group health

plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

(2) *Disclosure of grandfather status*—(i) To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.

(ii) The following model language can be used to satisfy this disclosure requirement:

This [group health plan or health insurance issuer] believes this [plan or coverage] is a ''grandfathered health plan'' under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at [insert contact information]. [For ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.] [For individual market policies and nonfederal governmental plans, insert: You may also contact the U.S. Department of Health and Human Services at *www.healthreform.gov*.]

(3)(i) *Documentation of plan or policy terms on March 23, 2010*. To maintain status as a grandfathered health plan, a group health plan, or group health insurance coverage, must, for as long as the plan or health insurance coverage takes the position that it is a grandfathered health plan—

(A) Maintain records documenting the terms of the plan or health insurance coverage in connection with the coverage in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its status as a grandfathered health plan; and

(B) Make such records available for examination upon request.

(ii) *Change in group health insurance coverage*. To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered health plan status under paragraph (g)(1) of this section has occurred.

(4) *Family members enrolling after March 23, 2010*. With respect to an individual who is enrolled in a group health plan or health insurance coverage on March 23, 2010, grandfathered health plan coverage includes coverage of family members of the individual who enroll after March 23, 2010 in the grandfathered health plan coverage of the individual.

(b) *Allowance for new employees to join current plan*—(1) *In general*. Subject to paragraph (b)(2) of this section, a group health plan (including health insurance coverage provided in connection with the group health plan) that provided coverage on March 23, 2010 and has retained its status as a grandfathered health plan (consistent with the rules of this section, including paragraph (g) of this section) is grandfathered health plan coverage for new employees (whether newly hired or newly enrolled) and their families enrolling in the plan after March 23, 2010.

(2) *Anti-abuse rules*—(i) *Mergers and acquisitions*. If the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered health plan, the plan ceases to be a grandfathered health plan.

(ii) *Change in plan eligibility*. A group health plan or health insurance coverage (including a benefit package under a group health plan) ceases to be a grandfathered health plan if—

(A) Employees are transferred into the plan or health insurance coverage (the transferee plan) from a plan or health insurance coverage under which the employees were covered on March 23, 2010 (the transferor plan);

(B) Comparing the terms of the transferee plan with those of the transferor plan (as in effect on March 23, 2010) and treating the transferee plan as if it were an amendment of the transferor plan would cause a loss of grandfather status under the provisions of paragraph (g)(1) of this section; and

(C) There was no bona fide employment-based reason to transfer the employees into the transferee plan. For this purpose, changing the terms or cost of coverage is not a bona fide employment-based reason.

(3) *Examples*. The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan offers two benefit packages on March 23, 2010, Options F and G. During a subsequent open enrollment period, some of the employees enrolled in Option F on March 23, 2010 switch to Option G.

(ii) *Conclusion*. In this *Example 1*, the group health coverage provided under Option G remains a grandfathered health plan under the rules of paragraph (b)(1) of this section because employees previously enrolled in Option F are allowed to enroll in Option G as new employees.

Example 2. (i) *Facts*. Same facts as *Example 1*, except that the plan sponsor eliminates Option F because of its high cost and transfers employees covered under Option F to Option G. If instead of transferring employees from Option F to Option G, Option F was amended to match the terms of Option G, then Option F would cease to be a grandfathered health plan.

(ii) *Conclusion*. In this *Example 2*, the plan did not have a bona fide employment-based reason to transfer employees from Option F to Option G. Therefore, Option G ceases to be a grandfathered health plan with respect to all employees. (However, any other benefit package maintained by the plan sponsor is analyzed separately under the rules of this section.)

Example 3. (i) *Facts*. A group health plan offers two benefit packages on March 23, 2010, Options H and I. On March 23, 2010, Option H provides coverage only for employees in one manufacturing plant. Subsequently, the plant is closed, and some employees in the closed plant are moved to another plant. The employer eliminates Option H and the employees that are moved are transferred to Option I. If instead of transferring employees from Option H to Option I, Option H was amended to match the terms of Option I, then Option H would cease to be a grandfathered health plan.

(ii) *Conclusion*. In this *Example 3*, the plan has a bona fide employment-based reason to transfer employees from Option H to Option I. Therefore, Option I does not cease to be a grandfathered health plan.

(c) *General grandfathering rule*—(1) Except as provided in paragraphs (d) and (e) of this section, subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into section 9815 and ERISA section 715) do not apply to grandfathered health plan coverage. Accordingly, the provisions of PHS Act sections 2701, 2702, 2703, 2705, 2706, 2707, 2709 (relating to coverage for individuals participating in approved clinical trials, as added by section 10103 of the Patient Protection and Affordable Care Act), 2713, 2715A, 2716, 2717, 2719, and 2719A, as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans. (In addition, *see* 45 CFR 147.140(c), which provides that the provisions of PHS Act section 2704, and PHS Act section 2711 insofar as it relates to annual limits, do not apply to grandfathered health plans that are individual health insurance coverage.)

(2) To the extent not inconsistent with the rules applicable to a grandfathered health plan, a grandfathered health plan must comply with the requirements of the Code, the PHS Act, and ERISA applicable prior to the changes enacted by the Patient Protection and Affordable Care Act.

(d) *Provisions applicable to all grandfathered health plans*. The provisions of

PHS Act section 2711 insofar as it relates to lifetime limits, and the provisions of PHS Act sections 2712, 2714, 2715, and 2718, apply to grandfathered health plans for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2708 apply to grandfathered health plans for plan years beginning on or after January 1, 2014.

(e) *Applicability of PHS Act sections 2704, 2711, and 2714 to grandfathered group health plans and group health insurance coverage*—(1) The provisions of PHS Act section 2704 as it applies with respect to enrollees who are under 19 years of age, and the provisions of PHS Act section 2711 insofar as it relates to annual limits, apply to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after September 23, 2010. The provisions of PHS Act section 2704 apply generally to grandfathered health plans that are group health plans (including group health insurance coverage) for plan years beginning on or after January 1, 2014.

(2) For plan years beginning before January 1, 2014, the provisions of PHS Act section 2714 apply in the case of an adult child with respect to a grandfathered health plan that is a group health plan only if the adult child is not eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2)) other than a grandfathered health plan of a parent. For plan years beginning on or after January 1, 2014, the provisions of PHS Act section 2714 apply with respect to a grandfathered health plan that is a group health plan without regard to whether an adult child is eligible to enroll in any other coverage.

(f) *Effect on collectively bargained plans—In general.* In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before March 23, 2010, the coverage is grandfathered health plan coverage at least until the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage that amends the coverage solely to conform to any requirement added by subtitles A and C of title I of the Patient Protection and Affordable Care Act (and the amendments made by those subtitles, and the incorporation of those amendments into section 9815 and ERISA section 715) is not treated as a termination of the collective bargaining agreement. After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).

(g) *Maintenance of grandfather status*—(1) *Changes causing cessation of grandfather status.* Subject to paragraph (g)(2) of this section, the rules of this paragraph (g)(1) describe situations in which a group health plan or health insurance coverage ceases to be a grandfathered health plan.

(i) *Elimination of benefits.* The elimination of all or substantially all benefits to diagnose or treat a particular condition causes a group health plan or health insurance coverage to cease to be a grandfathered health plan. For this purpose, the elimination of benefits for any necessary element to diagnose or treat a condition is considered the elimination of all or substantially all benefits to diagnose or treat a particular condition.

(ii) *Increase in percentage cost-sharing requirement.* Any increase, measured from March 23, 2010, in a percentage cost-sharing requirement (such as an individual's coinsurance requirement) causes a group health plan or health insurance coverage to cease to be a grandfathered health plan.

(iii) *Increase in a fixed-amount cost-sharing requirement other than a copayment.* Any increase in a fixed-amount cost-sharing requirement other than a

copayment (for example, deductible or out-of-pocket limit), determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total percentage increase in the cost-sharing requirement measured from March 23, 2010 exceeds the maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section).

(iv) *Increase in a fixed-amount copayment.* Any increase in a fixed-amount copayment, determined as of the effective date of the increase, causes a group health plan or health insurance coverage to cease to be a grandfathered health plan, if the total increase in the copayment measured from March 23, 2010 exceeds the greater of:

(A) An amount equal to $5 increased by medical inflation, as defined in paragraph (g)(3)(i) of this section (that is, $5 times medical inflation, plus $5), or

(B) The maximum percentage increase (as defined in paragraph (g)(3)(ii) of this section), determined by expressing the total increase in the copayment as a percentage.

(v) *Decrease in contribution rate by employers and employee organizations*—(A) *Contribution rate based on cost of coverage.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on cost of coverage (as defined in paragraph (g)(3)(iii)(A) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 54.9802–1(d)) by more than 5 percentage points below the contribution rate for the coverage period that includes March 23, 2010.

(B) *Contribution rate based on a formula.* A group health plan or group health insurance coverage ceases to be a grandfathered health plan if the employer or employee organization decreases its contribution rate based on a formula (as defined in paragraph (g)(3)(iii)(B) of this section) towards the cost of any tier of coverage for any class of similarly situated individuals (as described in § 54.9802–1(d)) by more than 5 percent below the contribution rate for the coverage period that includes March 23, 2010.

(vi) *Changes in annual limits*—(A) *Addition of an annual limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.

(B) *Decrease in limit for a plan or coverage with only a lifetime limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall lifetime limit on the dollar value of all benefits but no overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage adopts an overall annual limit at a dollar value that is lower than the dollar value of the lifetime limit on March 23, 2010.

(C) *Decrease in limit for a plan or coverage with an annual limit.* A group health plan, or group health insurance coverage, that, on March 23, 2010, imposed an overall annual limit on the dollar value of all benefits ceases to be a grandfathered health plan if the plan or health insurance coverage decreases the dollar value of the annual limit (regardless of whether the plan or health insurance coverage also imposed an overall lifetime limit on March 23, 2010 on the dollar value of all benefits).

(2) *Transitional rules*—(i) *Changes made prior to March 23, 2010.* If a group health plan or health insurance issuer makes the following changes to the terms of the plan or health insurance coverage, the changes are considered part of the terms of the plan or health insurance coverage on March 23, 2010 even though they were not effective at that time and such changes do not cause a plan or health insurance coverage to cease to be a grandfathered health plan:

(A) Changes effective after March 23, 2010 pursuant to a legally binding contract entered into on or before March 23, 2010;

(B) Changes effective after March 23, 2010 pursuant to a filing on or before March 23, 2010 with a State insurance department; or

(C) Changes effective after March 23, 2010 pursuant to written amendments to a plan that were adopted on or before March 23, 2010.

(ii) *Changes made after March 23, 2010 and adopted prior to issuance of regulations.* If, after March 23, 2010, a group health plan or health insurance issuer makes changes to the terms of the plan or health insurance coverage and the changes are adopted prior to June 14, 2010, the changes will not cause the plan or health insurance coverage to cease to be a grandfathered health plan if the changes are revoked or modified effective as of the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, and the terms of the plan or health insurance coverage on that date, as modified, would not cause the plan or coverage to cease to be a grandfathered health plan under the rules of this section, including paragraph (g)(1) of this section. For this purpose, changes will be considered to have been adopted prior to June 14, 2010 if:

(A) The changes are effective before that date;

(B) The changes are effective on or after that date pursuant to a legally binding contract entered into before that date;

(C) The changes are effective on or after that date pursuant to a filing before that date with a State insurance department; or

(D) The changes are effective on or after that date pursuant to written amendments to a plan that were adopted before that date.

(3) *Definitions*—(i) *Medical inflation defined.* For purposes of this paragraph (g), the term *medical inflation* means the increase since March 2010 in the overall medical care component of the Consumer Price Index for All Urban Consumers (CPI–U) (unadjusted) published by the Department of Labor using the 1982–1984 base of 100. For this purpose, the increase in the overall medical care component is computed by subtracting 387.142 (the overall medical care component of the CPI–U (unadjusted) published by the Department of Labor for March 2010, using the 1982–1984 base of 100) from the index amount for any month in the 12 months before the new change is to take effect and then dividing that amount by 387.142.

(ii) *Maximum percentage increase defined.* For purposes of this paragraph (g), the term *maximum percentage increase* means medical inflation (as defined in paragraph (g)(3)(i) of this section), expressed as a percentage, plus 15 percentage points.

(iii) *Contribution rate defined.* For purposes of paragraph (g)(1)(v) of this section:

(A) *Contribution rate based on cost of coverage.* The term *contribution rate based on cost of coverage* means the amount of contributions made by an employer or employee organization compared to the total cost of coverage, expressed as a percentage. The total cost of coverage is determined in the same manner as the applicable premium is calculated under the COBRA continuation provisions of section 4980B(f)(4), section 604 of ERISA, and section 2204 of the PHS Act. In the case of a self-insured plan, contributions by an employer or employee organization are equal to the total cost of coverage minus the employee contributions towards the total cost of coverage.

(B) *Contribution rate based on a formula.* The term *contribution rate based on a formula* means, for plans that, on March 23, 2010, made contributions based on a formula (such as hours worked or tons of coal mined), the formula.

(4) *Examples.* The rules of this paragraph (g) are illustrated by the following examples:

Example 1. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a coinsurance requirement of 20% for inpatient surgery. The plan is subsequently amended to increase the coinsurance requirement to 25%.

(ii) *Conclusion.* In this *Example 1,* the increase in the coinsurance requirement from 20% to 25% causes the plan to cease to be a grandfathered health plan.

Example 2. (i) *Facts.* Before March 23, 2010, the terms of a group health plan provide benefits for a particular mental health condition, the treatment for which is a combination of counseling and prescription drugs. Subsequently, the plan eliminates benefits for counseling.

(ii) *Conclusion.* In this *Example 2,* the plan ceases to be a grandfathered health plan because counseling is an element that is necessary to treat the condition. Thus the plan

is considered to have eliminated substantially all benefits for the treatment of the condition.

Example 3. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a copayment requirement of $30 per office visit for specialists. The plan is subsequently amended to increase the copayment requirement to $40. Within the 12-month period before the $40 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 475.

(ii) *Conclusion.* In this *Example 3,* the increase in the copayment from $30 to $40, expressed as a percentage, is 33.33% (40 − 30 = 10; 10 ÷ 30 = 0.3333; 0.3333 = 33.33%). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2269 (475 − 387.142 = 87.858; 87.858 ÷ 387.142 = 0.2269). The maximum percentage increase permitted is 37.69% (0.2269 = 22.69%; 22.69% + 15% = 37.69%). Because 33.33% does not exceed 37.69%, the change in the copayment requirement at that time does not cause the plan to cease to be a grandfathered health plan.

Example 4. (i) *Facts.* Same facts as *Example 3,* except the grandfathered health plan subsequently increases the $40 copayment requirement to $45 for a later plan year. Within the 12-month period before the $45 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 485.

(ii) *Conclusion.* In this *Example 4,* the increase in the copayment from $30 (the copayment that was in effect on March 23, 2010) to $45, expressed as a percentage, is 50% (45 − 30 = 15; 15 ÷ 30 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.2527 (485 − 387.142 = 97.858; 97.858 ÷ 387.142 = 0.2527). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 40.27% (0.2527 = 25.27%; 25.27% + 15% = 40.27%), or $6.26 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26). Because 50% exceeds 40.27% and $15 exceeds $6.26, the change in the copayment requirement at that time causes the plan to cease to be a grandfathered health plan.

Example 5. (i) *Facts.* On March 23, 2010, a grandfathered health plan has a copayment of $10 per office visit for primary care providers. The plan is subsequently amended to increase the copayment requirement to $15. Within the 12-month period before the $15 copayment takes effect, the greatest value of the overall medical care component of the CPI–U (unadjusted) is 415.

(ii) *Conclusion.* In this *Example 5,* the increase in the copayment, expressed as a percentage, is 50% (15 − 10 = 5; 5 ÷ 10 = 0.5; 0.5 = 50%). Medical inflation (as defined in paragraph (g)(3) of this section) from March 2010 is 0.0720 (415.0 − 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv) of this section is the greater of the maximum percentage increase of 22.20% (0.0720 = 7.20%; 7.20% + 15% = 22.20), or $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 5* would not cause the plan to cease to be a grandfathered health plan pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 6. (i) *Facts.* The same facts as *Example 5,* except on March 23, 2010, the grandfathered health plan has no copayment ($0) for office visits for primary care providers. The plan is subsequently amended to increase the copayment requirement to $5.

(ii) *Conclusion.* In this *Example 6,* medical inflation (as defined in paragraph (g)(3)(i) of this section) from March 2010 is 0.0720 (415.0 − 387.142 = 27.858; 27.858 ÷ 387.142 = 0.0720). The increase that would cause a plan to cease to be a grandfathered health plan under paragraph (g)(1)(iv)(A) of this section is $5.36 ($5 × 0.0720 = $0.36; $0.36 + $5 = $5.36). The $5 increase in copayment in this *Example 6* is less than the amount calculated pursuant to paragraph (g)(1)(iv)(A) of this section of $5.36. Thus, the $5 increase in copayment does not cause the plan to cease to be a grandfathered health plan.

Example 7. (i) *Facts.* On March 23, 2010, a self-insured group health plan provides two tiers of coverage—self-only and family. The employer contributes 80% of the total cost of coverage for self-only and 60% of the total cost of coverage for family. Subsequently, the employer reduces the contribution to 50% for family coverage, but keeps the same contribution rate for self-only coverage.

(ii) *Conclusion.* In this *Example 7,* the decrease of 10 percentage points for family coverage in the contribution rate based on cost of coverage causes the plan to cease to be a grandfathered health plan. The fact that the contribution rate for self-only coverage remains the same does not change the result.

Example 8. (i) *Facts.* On March 23, 2010, a self-insured grandfathered health plan has a COBRA premium for the 2010 plan year of $5000 for self-only coverage and $12,000 for family coverage. The required employee contribution for the coverage is $1000 for self-only coverage and $4000 for family coverage. Thus, the contribution rate based on cost of coverage for 2010 is 80% ((5000 − 1000)/5000) for self-only coverage and 67% ((12,000 − 4000)/12,000) for family coverage. For a subsequent plan year, the COBRA premium is $6000 for self-only coverage and $15,000 for family coverage. The employee contributions for that plan year are $1200 for self-only coverage and $5000 for family coverage. Thus, the contribution rate based on cost of coverage is 80% ((6000 − 1200)/6000) for self-only coverage and 67% ((15,000 − 5000)/15,000) for family coverage.

(ii) *Conclusion*. In this *Example 8*, because there is no change in the contribution rate based on cost of coverage, the plan retains its status as a grandfathered health plan. The result would be the same if all or part of the employee contribution was made pre-tax through a cafeteria plan under section 125 of the Internal Revenue Code.

Example 9. (i) *Facts*. A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option H from 10% to 15%.

(ii) *Conclusion*. In this *Example 9*, the coverage under Option H is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options F and G is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

(h) *Expiration date*. This section expires on or before June 14, 2013.

[T.D. 9489, 75 FR 34558, June 17, 2010, as amended by T.D. 9506, 75 FR 70120, Nov. 17, 2010]

§ 54.9815–2704T Prohibition of preexisting condition exclusions (temporary).

(a) *No preexisting condition exclusions*—(1) *In general*. A group health plan, or a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion (as defined in § 54.9801–2).

(2) *Examples*. The rules of this paragraph (a) are illustrated by the following examples (for additional examples illustrating the definition of a preexisting condition exclusion, see § 54.9801–3(a)(1)(ii)):

Example 1. (i) *Facts*. A group health plan provides benefits solely through an insurance policy offered by Issuer P. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer N. N's policy excludes benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage under the policy.

(ii) *Conclusion*. In this *Example 1*, the exclusion of benefits for oral surgery required as a result of a traumatic injury if the injury occurred before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy.

Example 2. (i) *Facts*. Individual C applies for individual health insurance coverage with Issuer M. M denies C's application for coverage because a pre-enrollment physical revealed that C has type 2 diabetes.

(ii) *Conclusion*. *See Example 2* in 45 CFR 147.108(a)(2) for a conclusion that M's denial of C's application for coverage is a preexisting condition exclusion because a denial of an application for coverage based on the fact that a condition was present before the date of denial is an exclusion of benefits based on a preexisting condition.

(b) *Effective/applicability date*—(1) *General applicability date*. Except as provided in paragraph (b)(2) of this section, the rules of this section apply for plan years beginning on or after January 1, 2014.

(2) *Early applicability date for children*. The rules of this section apply with respect to enrollees, including applicants for enrollment, who are under 19 years of age for plan years beginning on or after September 23, 2010.

(3) *Applicability to grandfathered health plans*. See § 54.9815–1251T for determining the application of this section to grandfathered health plans (providing that a grandfathered health plan that is a group health plan or group health insurance coverage must comply with the prohibition against preexisting condition exclusions).

(4) *Example*. The rules of this paragraph (b) are illustrated by the following example:

Example. (i) *Facts*. Individual F commences employment and enrolls F and F's 16-year-old child in the group health plan maintained by F's employer, with a first day of coverage of October 15, 2010. F's child had a significant break in coverage because of a lapse of more than 63 days without creditable coverage immediately prior to enrolling in the plan. F's child was treated for asthma within the six-month period prior to the enrollment date and the plan imposes a 12-month preexisting condition exclusion for coverage of asthma. The next plan year begins on January 1, 2011.

(ii) *Conclusion*. In this *Example*, the plan year beginning January 1, 2011 is the first plan year of the group health plan beginning on or after September 23, 2010. Thus, beginning on January 1, 2011, because the child is under 19 years of age, the plan cannot impose a preexisting condition exclusion with respect to the child's asthma regardless of the fact that the preexisting condition exclusion was imposed by the plan before the applicability date of this provision.

(c) *Expiration date*. This section expires on June 21, 2013.

[T.D. 9491, 75 FR 37223, June 28, 2010]

§ 54.9815–2711T No lifetime or annual limits (temporary).

(a) *Prohibition*—(1) *Lifetime limits*. Except as provided in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any lifetime limit on the dollar amount of benefits for any individual.

(2) *Annual limits*—(i) *General rule*. Except as provided in paragraphs (a)(2)(ii), (b), and (d) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, may not establish any annual limit on the dollar amount of benefits for any individual.

(ii) *Exception for health flexible spending arrangements*. A health flexible spending arrangement (as defined in section 106(c)(2)) is not subject to the requirement in paragraph (a)(2)(i) of this section.

(b) *Construction*—(1) *Permissible limits on specific covered benefits*. The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable Federal or State law. (The scope of essential health benefits is addressed in paragraph (c) of this section.)

(2) *Condition-based exclusions*. The rules of this section do not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this section apply. Other requirements of Federal or State law may require coverage of certain benefits.

(c) *Definition of essential health benefits*. The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

(d) *Restricted annual limits permissible prior to 2014*—(1) *In general*. With respect to plan years beginning prior to January 1, 2014, a group health plan, or a health insurance issuer offering group health insurance coverage, may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the amounts in the following schedule:

(i) For a plan year beginning on or after September 23, 2010, but before September 23, 2011, $750,000.

(ii) For a plan year beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.

(iii) For plan years beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.

(2) *Only essential health benefits taken into account*. In determining whether an individual has received benefits that meet or exceed the applicable amount described in paragraph (d)(1) of this section, a plan or issuer must take into account only essential health benefits.

(3) *Waiver authority of the Secretary of Health and Human Services*. For plan years beginning before January 1, 2014, the Secretary of Health and Human Services may establish a program under which the requirements of paragraph (d)(1) of this section relating to annual limits may be waived (for such period as is specified by the Secretary of Health and Human Services) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits provided under paragraph (d)(1) of this section if compliance with paragraph (d)(1) of this section would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.

(e) *Transitional rules for individuals whose coverage or benefits ended by reason of reaching a lifetime limit*—(1) *In general*. The relief provided in the transitional rules of this paragraph (e) applies with respect to any individual—

(i) Whose coverage or benefits under a group health plan or group health insurance coverage ended by reason of reaching a lifetime limit on the dollar

value of all benefits for any individual (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010, by reason of the application of this section.

(2) *Notice and enrollment opportunity requirements*—(i) If an individual described in paragraph (e)(1) of this section is eligible for benefits (or is required to become eligible for benefits) under the group health plan—or group health insurance coverage—described in paragraph (e)(1) of this section, the plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity required under this paragraph (e)(2)(i) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

(ii) The notices required under paragraph (e)(2)(i) of this section may be provided to an employee on behalf of the employee's dependent. In addition, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, if a notice satisfying the requirements of this paragraph (e)(2) is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

(3) *Effective date of coverage*. In the case of an individual who enrolls under paragraph (e)(2) of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan*. Any individual enrolling in a group health plan pursuant to paragraph (e)(2) of this section must be treated as if the individual were a special enrollee, as provided under the rules of § 54.9801–6(d). Accordingly, the individual (and, if the individual would not be a participant once enrolled in the plan, the participant through whom the individual is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits.

(5) *Examples*. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts*. Employer Y maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For plan years beginning before September 23, 2010, the plan has a lifetime limit on the dollar value of all benefits. Individual B, an employee of Y, was enrolled in Y's group health plan at the beginning of the 2008 plan year. On June 10, 2008, B incurred a claim for benefits that exceeded the lifetime limit under Y's plan and ceased to be enrolled in the plan. B is still eligible for coverage under Y's group health plan. On or before January 1, 2011, Y's group health plan gives B written notice informing B that the lifetime limit on the dollar value of all benefits no longer applies, that individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan, and that individuals can request such enrollment through February 1, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion*. In this *Example 1*, the plan has complied with the requirements of this paragraph (e) by providing a timely written notice and enrollment opportunity to B that lasts at least 30 days.

Example 2. (i) *Facts*. Employer Z maintains a group health plan with a plan year beginning October 1 and ending September 30.

Prior to October 1, 2010, the group health plan has a lifetime limit on the dollar value of all benefits. Individual D, an employee of Z, and Individual E, D's child, were enrolled in family coverage under Z's group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, E incurred a claim for benefits that exceeded the lifetime limit under Z's plan. D dropped family coverage but remains an employee of Z and is still eligible for coverage under Z's group health plan.

(ii) *Conclusion*. In this *Example 2*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts*. Same facts as *Example 2*, except that Z's plan had two benefit packages (a low-cost and a high-cost option). Instead of dropping coverage, D switched to the low-cost benefit package option.

(ii) *Conclusion*. In this *Example 3*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible. The plan would have to provide D and E the opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible, even if D had not switched to the low-cost benefit package option.

Example 4. (i) *Facts*. Employer Q maintains a group health plan with a plan year beginning October 1 and ending September 30. For the plan year beginning on October 1, 2009, Q has an annual limit on the dollar value of all benefits of $500,000.

(ii) *Conclusion*. In this *Example 4*, Q must raise the annual limit on the dollar value of essential health benefits to at least $750,000 for the plan year beginning October 1, 2010. For the plan year beginning October 1, 2011, Q must raise the annual limit to at least $1.25 million. For the plan year beginning October 1, 2012, Q must raise the annual limit to at least $2 million. Q may also impose a restricted annual limit of $2 million for the plan year beginning October 1, 2013. After the conclusion of that plan year, Q cannot impose an overall annual limit.

Example 5. (i) *Facts*. Same facts as *Example 4*, except that the annual limit for the plan year beginning on October 1, 2009 is $1 million and Q lowers the annual limit for the plan year beginning October 1, 2010 to $750,000.

(ii) *Conclusion*. In this *Example 5*, Q complies with the requirements of this paragraph (e). However, Q's choice to lower its annual limit means that under § 54.9815–1251T(g)(1)(vi)(C), the group health plan will cease to be a grandfathered health plan and will be generally subject to all of the provisions of PHS Act sections 2701 through 2719A.

(f) *Effective/applicability date*. The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 54.9815–1251T for determining the application of this section to grandfathered health plans (providing that the prohibitions on lifetime and annual limits apply to all grandfathered health plans that are group health plans and group health insurance coverage, including the special rules regarding restricted annual limits).

(g) *Expiration date*. This section expires on June 21, 2013.

[T.D. 9491, 75 FR 37223, June 28, 2010]

§ 54.9815–2712T Rules regarding rescissions (temporary).

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group health insurance coverage, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the

time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if—

(i) The cancellation or discontinuance of coverage has only a prospective effect; or

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual A seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires A to complete a questionnaire regarding A's prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: ''Is there anything else relevant to your health that we should know?'' A inadvertently fails to list that A visited a psychologist on two occasions, six years previously. A is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about A's visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1,* the plan cannot rescind A's coverage because A's failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual B has coverage under the plan as a full-time employee. The employer reassigns B to a part-time position. Under the terms of the plan, B is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from B and paying claims submitted by B. After a routine audit, the plan discovers that B no longer works at least 30 hours per week. The plan rescinds B's coverage effective as of the date that B changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2,* the plan cannot rescind B's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for B prospectively, subject to other applicable Federal and State laws.

(b) *Compliance with other requirements.* Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Effective/applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. See § 54.9815–1251T for determining the application of this section to grandfathered health plans (providing that the rules regarding rescissions and advance notice apply to all grandfathered health plans).

(d) *Expiration date.* This section expires on June 21, 2013.

[T.D. 9491, 75 FR 37225, June 28, 2010]

§ 54.9815–2713 Coverage of preventive health services.

(a) *Services*—(1) *In general.* [Reserved]

(i)–(iii) [Reserved]

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of § 54.9815–2713T, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration and developed in accordance with 45 CFR 147.130(a)(1)(iv).

(2) *Office visits.* [Reserved]

(3) *Out-of-network providers.* [Reserved]

(4) *Reasonable medical management.* [Reserved]

(5) *Services not described.* [Reserved]

(b) *Timing.* [Reserved]

(c) *Recommendations not current.* [Reserved]

(d) *Effective/applicability date.* April 16, 2012.

[T.D. 9578, 77 FR 8729, Feb. 15, 2012]

EFFECTIVE DATE NOTE: By T.D. 9578, 77 FR 8729, Feb. 15, 2012, § 54.9815–2713 was added, effective Apr. 16, 2012.

§ 54.9815–2713T Coverage of preventive health services (temporary).

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, must

provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration and developed in accordance with 45 CFR 147.130(a)(1)(iv).

(2) *Office visits*—(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

(iii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(iv) The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider. While visiting the provider, the individual is screened for cholesterol abnormalities, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit and for the laboratory work of the cholesterol screening test.

(ii) *Conclusion.* In this *Example 1,* the plan may not impose any cost-sharing requirements with respect to the separately-billed laboratory work of the cholesterol screening test. Because the office visit is billed separately from the cholesterol screening test, the plan may impose cost-sharing requirements for the office visit.

Example 2. (i) *Facts.* Same facts as *Example 1.* As the result of the screening, the individual is diagnosed with hyperlipidemia and is prescribed a course of treatment that is not included in the recommendations under paragraph (a)(1) of this section.

(ii) *Conclusion.* In this *Example 2,* because the treatment is not included in the recommendations under paragraph (a)(1) of this section, the plan is not prohibited from imposing cost-sharing requirements with respect to the treatment.

Example 3. (i) *Facts.* An individual covered by a group health plan visits an in-network health care provider to discuss recurring abdominal pain. During the visit, the individual has a blood pressure screening, which has in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 3,* the blood pressure screening is provided as part of an office visit for which the primary purpose was not to deliver items or services described

in paragraph (a)(1) of this section. Therefore, the plan may impose a cost-sharing requirement for the office visit charge.

Example 4. (i) *Facts.* A child covered by a group health plan visits an in-network pediatrician to receive an annual physical exam described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. During the office visit, the child receives additional items and services that are not described in the comprehensive guidelines supported by the Health Resources and Services Administration, nor otherwise described in paragraph (a)(1) of this section. The provider bills the plan for an office visit.

(ii) *Conclusion.* In this *Example 4*, the service was not billed as a separate charge and was billed as part of an office visit. Moreover, the primary purpose for the visit was to deliver items and services described as part of the comprehensive guidelines supported by the Health Resources and Services Administration. Therefore, the plan may not impose a cost-sharing requirement with respect to the office visit.

(3) *Out-of-network providers.* Nothing in this section requires a plan or issuer that has a network of providers to provide benefits for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider. Moreover, nothing in this section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in paragraph (a)(1) of this section that are delivered by an out-of-network provider.

(4) *Reasonable medical management.* Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in paragraph (a)(1) of this section to the extent not specified in the recommendation or guideline.

(5) *Services not described.* Nothing in this section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in paragraph (a)(1) of this section, even if the treatment results from an item or service described in paragraph (a)(1) of this section.

(b) *Timing*—(1) *In general.* A plan or issuer must provide coverage pursuant to paragraph (a)(1) of this section for plan years that begin on or after September 23, 2010, or, if later, for plan years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(2) *Changes in recommendations or guidelines.* A plan or issuer is not required under this section to provide coverage for any items and services specified in any recommendation or guideline described in paragraph (a)(1) of this section after the recommendation or guideline is no longer described in paragraph (a)(1) of this section. Other requirements of Federal or State law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective.

(c) *Recommendations not current.* For purposes of paragraph (a)(1)(i) of this section, and for purposes of any other provision of law, recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not considered to be current.

(d) *Effective/applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 54.9815–1251T for determining the application of this section to grandfathered health plans (providing that these rules regarding coverage of preventive health services do not apply to grandfathered health plans).

(e) *Expiration date.* This section expires on *July 12, 2013* or on such earlier

date as may be provided in final regulations or other action published in the FEDERAL REGISTER.

[T.D. 9493, 75 FR 41756, July 19, 2010, as amended by T.D. 9541, 76 FR 46625, Aug. 3, 2011]

EFFECTIVE DATE NOTE: By T.D. 9578, 77 FR 8729, Feb. 15, 2012, § 54.9815–2713T was amended in paragraph (a)(1)(iii) by removing ''; and'' and adding a period in its place, and by removing paragraph (a)(1)(iv), effective Apr. 16, 2012.

§ 54.9815–2714T Eligibility of children until at least age 26 (temporary).

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts*. For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion*. In this *Example*, the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent*. With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors. In addition, a plan or issuer may not deny or restrict coverage of a child based on eligibility for other coverage, except that paragraph (g) of this section provides a special rule for plan years beginning before January 1, 2014 for grandfathered health plans that are group health plans. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may mandate coverage of certain children.)

(c) *Coverage of grandchildren not required*. Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age*. The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

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

Example 1. (i) *Facts*. A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

(ii) *Conclusion*. In this *Example 1*, the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts*. A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

(ii) *Conclusion*. In this *Example 2*, the plan does not violate the requirement of paragraph (d) of this section that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example 3. (i) *Facts*. A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion*. In this *Example 3*, the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

(f) *Transitional rules for individuals whose coverage ended by reason of reaching a dependent eligibility threshold*—(1) *In general.* The relief provided in the transitional rules of this paragraph (f) applies with respect to any child—

(i) Whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010 by reason of the application of this section.

(2) *Opportunity to enroll required.* (i) If a group health plan, or group health insurance coverage, in which a child described in paragraph (f)(1) of this section is eligible to enroll (or is required to become eligible to enroll) is the plan or coverage in which the child's coverage ended (or did not begin) for the reasons described in paragraph (f)(1)(i) of this section, and if the plan, or the issuer of such coverage, is subject to the requirements of this section, the plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

(ii) The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. If a notice satisfying the requirements of this paragraph (f)(2) is provided to an employee whose child is entitled to an enrollment opportunity under this paragraph (f), the obligation to provide the notice of enrollment opportunity under this paragraph (f)(2) with respect to that child is satisfied for both the plan and the issuer.

(3) *Effective date of coverage.* In the case of an individual who enrolls under paragraph (f)(2) of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan.* Any child enrolling in a group health plan pursuant to paragraph (f)(2) of this section must be treated as if the child were a special enrollee, as provided under the rules of § 54.9801–6(d). Accordingly, the child (and, if the child would not be a participant once enrolled in the plan, the participant through whom the child is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(5) *Examples.* The rules of this paragraph (f) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer Y maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For the 2010 plan year, the plan allows children of employees to be covered under the plan until age 19, or until age 23 for children who are full-time students. Individual B, an employee of Y, and Individual C, B's child and a full-time student, were enrolled in Y's group health plan at the beginning of the 2010 plan year. On June 10, 2010, C turns 23 years old and loses dependent coverage under Y's plan. On or before January 1, 2011, Y's group health plan gives B written notice that individuals who lost coverage by reason of ceasing to be a dependent before attainment of age 26 are eligible to enroll in the plan, and that individuals may request enrollment for such children through February 14, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion*. In this *Example 1*, the plan has complied with the requirements of this paragraph (f) by providing an enrollment opportunity to C that lasts at least 30 days.

Example 2. (i) *Facts*. Employer Z maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Individual D, an employee of Z, and Individual E, D's child, are enrolled in family coverage under Z's group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, E turns 22 years old and ceases to be eligible as a dependent under Z's plan and loses coverage. D drops coverage but remains an employee of Z.

(ii) *Conclusion*. In this *Example 2*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts*. Same facts as *Example 2*, except that D did not drop coverage. Instead, D switched to a lower-cost benefit package option.

(ii) *Conclusion*. In this *Example 3*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible.

Example 4. (i) *Facts*. Same facts as *Example 2*, except that E elected COBRA continuation coverage.

(ii) *Conclusion*. In this *Example 4*, not later than October 1, 2010, the plan must provide D and E an opportunity to enroll other than as a COBRA qualified beneficiary (and must provide, by that date, written notice of the opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 5. (i) *Facts*. Employer X maintains a group health plan with a calendar year plan year. Prior to 2011, the plan allows children of employees to be covered under the plan until the child attains age 22. During the 2009 plan year, an individual with a 22-year old child joins the plan; the child is denied coverage because the child is 22.

(ii) *Conclusion*. In this *Example 5*, notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

(g) *Special rule for grandfathered group health plans*—(1) For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2)) other than a group health plan of a parent.

(2) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act must comply with the requirements of paragraphs (a) through (f) of this section.

(h) *Applicability date*. The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 54.9815–1251T for determining the application of this section to grandfathered health plans.

(i) *Expiration date*. This section expires on or before May 10, 2013.

[T.D. 9482, 75 FR 27134, May 13, 2010, as amended by T.D. 9489, 75 FR 34562, June 17, 2010]

§ 54.9815–2715 Summary of benefits and coverage and uniform glossary.

(a) *Summary of benefits and coverage*—(1) *In general*. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for each benefit package without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section.

(i) *SBC provided by a group health insurance issuer to a group health plan*—(A) *Upon application*. A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

(B) *By first day of coverage (if there are changes)*. If there is any change in the information required to be in the SBC that was provided upon application and

before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

(C) *Upon renewal.* If the issuer renews or reissues the policy, certificate, or contract of insurance (for example, for a succeeding policy year), the issuer must provide a new SBC as follows:

(*1*) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

(*2*) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(D) *Upon request.* If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

(ii) *SBC provided by a group health insurance issuer and a group health plan to participants and beneficiaries*—(A) *In general.* A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with paragraph (a)(1)(iii) of this section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

(B) *Upon application.* The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries.

(C) *By first day of coverage (if there are changes).* If there is any change to the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

(D) *Special enrollees.* The plan or issuer must provide the SBC to special enrollees (as described in § 54.9801–6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) *Upon renewal.* If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or issuer must provide a new SBC when the coverage is renewed, as follows:

(*1*) If written application is required for renewal (in either paper or electronic form), the SBC must be provided no later than the date on which the written application materials are distributed.

(*2*) If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate, or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

(F) *Upon request.* A plan or issuer must provide the SBC to participants or beneficiaries upon request for an SBC or summary information about the health coverage, as soon as practicable, but in no event later than seven business days following receipt of the request.

(iii) *Special rules to prevent unnecessary duplication with respect to group health coverage*—(A) An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with the other rules of this section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual.

(B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

(C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled; SBCs are not required to be provided automatically upon renewal with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

(2) *Content*—(i) *In general.* Subject to paragraph (a)(2)(iii) of this section, the SBC must include the following:

(A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage, in accordance with guidance as specified by the Secretary;

(B) A description of the coverage, including cost sharing, for each category of benefits identified by the Secretary in guidance;

(C) The exceptions, reductions, and limitations of the coverage;

(D) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations;

(E) The renewability and continuation of coverage provisions;

(F) Coverage examples, in accordance with paragraph (a)(2)(ii) of this section;

(G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

(H) A statement that the SBC is only a summary and that the plan document, policy, certificate, or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

(I) Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate, or contract of insurance);

(J) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

(K) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and

(L) An Internet address for obtaining the uniform glossary, as described in paragraph (c) of this section, as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(ii) *Coverage examples.* The SBC must include coverage examples specified by the Secretary in guidance that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this paragraph (a)(2)(ii).

(A) *Number of examples.* The Secretary may identify up to six coverage examples that may be required in an SBC.

(B) *Benefits scenarios.* For purposes of this paragraph (a)(2)(ii), a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality. The Secretary will specify, in guidance, the assumptions, including the relevant items and services and reimbursement information, for each claim in the benefits scenario.

(C) *Illustration of benefit provided.* For purposes of this paragraph (a)(2)(ii), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing in accordance with guidance issued by the Secretary to generate an estimate of what an individual might expect to pay under the plan, policy, or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage, as specified by the Secretary in guidance.

(iii) *Coverage provided outside the United States.* In lieu of summarizing coverage for items and services provided outside the United States, a plan or issuer may provide an Internet address (or similar contact information) for obtaining information about benefits and coverage provided outside the United States. In any case, the plan or issuer must provide an SBC in accordance with this section that accurately summarizes benefits and coverage available under the plan or coverage within the United States.

(3) *Appearance.* A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee, not exceed four double-sided pages in length, and not include print smaller than 12-point font.

(4) *Form*—(i) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor), may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied—

(A) The format is readily accessible by the plan (or its sponsor);

(B) The SBC is provided in paper form free of charge upon request; and

(C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

(ii) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the requirements of this paragraph (a)(4)(ii) are met.

(A) With respect to participants and beneficiaries covered under the plan, the SBC may be provided electronically if the requirements of 29 CFR 2520.104b–1 are met.

(B) With respect to participants and beneficiaries who are eligible but not enrolled for coverage, the SBC may be provided electronically if—

(*1*) The format is readily accessible;

(*2*) The SBC is provided in paper form free of charge upon request; and

(*3*) In a case in which the electronic form is an Internet posting, the plan or issuer timely notifies the individual in paper form (such as a postcard) or email that the documents are available on the Internet, provides the Internet address, and notifies the individual that the documents are available in paper form upon request.

(5) *Language.* A group health plan or health insurance issuer must provide

the SBC in a culturally and linguistically appropriate manner. For purposes of this paragraph (a)(5), a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of §54.9815–2719T(e) are met as applied to the SBC.

(b) *Notice of modification*. If a group health plan, or health insurance issuer offering group health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with paragraph (a)(4) of this section.

(c) *Uniform glossary*—(1) *In general*. A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries the uniform glossary described in paragraph (c)(2) of this section in accordance with the appearance and the form and manner requirements of paragraphs (c)(3) and (4) of this section.

(2) *Health-coverage-related terms and medical terms*. The uniform glossary must provide uniform definitions, specified by the Secretary in guidance, of the following health-coverage-related terms and medical terms:

(i) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

(ii) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits), as specified in guidance.

(3) *Appearance*. A group health plan, and a health insurance issuer, must provide the uniform glossary with the appearance specified by the Secretary in guidance to ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee.

(4) *Form and manner*. A plan or issuer must make the uniform glossary described in this paragraph (c) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request.

(d) *Preemption*. State laws that require a health insurance issuer to provide an SBC that supplies less information than required under paragraph (a) of this section are preempted.

(e) *Failure to provide*. A group health plan or health insurance issuer that willfully fails to provide information required under this section to a participant or beneficiary is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each participant or beneficiary constitutes a separate offense for purposes of this paragraph (e).

(f) *Effective/Applicability date*—(1) This section is applicable to group health plans and group health insurance issuers in accordance with this paragraph (f). (*See* §54.9815–1251T(d), providing that this section applies to grandfathered health plans.)

(i) For disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including re-enrollees and late enrollees), this section applies beginning on the first day of the first

open enrollment period that begins on or after September 23, 2012; and

(ii) For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), this section applies beginning on the first day of the first plan year that begins on or after September 23, 2012.

(2) For disclosures with respect to plans, this section is applicable to health insurance issuers beginning September 23, 2012.

[T.D. 9575, 77 FR 8697, Feb. 14, 2012]

EFFECTIVE DATE NOTE: By T.D. 9575, 77 FR 8697, Feb. 14, 2012, § 54.9515–2715 was added, effective Apr. 16, 2012.

§ 54.9815–2719AT Patient protections (temporary).

(a) *Choice of health care professional*—(1) *Designation of primary care provider*—(i) *In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for designation by a participant or beneficiary of a participating primary care provider, then the plan or issuer must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider.

(ii) *Example.* The rules of this paragraph (a)(1) are illustrated by the following example:

Example. (i) *Facts.* A group health plan requires individuals covered under the plan to designate a primary care provider. The plan permits each individual to designate any primary care provider participating in the plan's network who is available to accept the individual as the individual's primary care provider. If an individual has not designated a primary care provider, the plan designates one until one has been designated by the individual. The plan provides a notice that satisfies the requirements of paragraph (a)(4) of this section regarding the ability to designate a primary care provider.

(ii) *Conclusion.* In this *Example,* the plan has satisfied the requirements of paragraph (a) of this section.

(2) *Designation of pediatrician as primary care provider*—(i) *In general.* If a group health plan, or a health insurance issuer offering group health insurance coverage, requires or provides for the designation of a participating primary care provider for a child by a participant or beneficiary, the plan or issuer must permit the participant or beneficiary to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if the provider participates in the network of the plan or issuer and is available to accept the child. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant of the terms of the plan or health insurance coverage regarding designation of a pediatrician as the child's primary care provider.

(ii) *Construction.* Nothing in paragraph (a)(2)(i) of this section is to be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan's HMO designates for each participant a physician who specializes in internal medicine to serve as the primary care provider for the participant and any beneficiaries. Participant A requests that Pediatrician B be designated as the primary care provider for A's child. B is a participating provider in the HMO's network.

(ii) *Conclusion.* In this *Example 1,* the HMO must permit A's designation of B as the primary care provider for A's child in order to comply with the requirements of this paragraph (a)(2).

Example 2. (i) *Facts.* Same facts as *Example 1,* except that A takes A's child to B for treatment of the child's severe shellfish allergies. B wishes to refer A's child to an allergist for treatment. The HMO, however, does not provide coverage for treatment of food allergies, nor does it have an allergist participating in its network, and it therefore refuses to authorize the referral.

(ii) *Conclusion.* In this *Example 2,* the HMO has not violated the requirements of this paragraph (a)(2) because the exclusion of

treatment for food allergies is in accordance with the terms of A's coverage.

(3) *Patient access to obstetrical and gynecological care*—(i) *General rights*—(A) *Direct access.* A group health plan, or a health insurance issuer offering group health insurance coverage, described in paragraph (a)(3)(ii) of this section may not require authorization or referral by the plan, issuer, or any person (including a primary care provider) in the case of a female participant or beneficiary who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. In such a case, the plan or issuer must comply with the rules of paragraph (a)(4) of this section by informing each participant that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology. The plan or issuer may require such a professional to agree to otherwise adhere to the plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer. For purposes of this paragraph (a)(3), a health care professional who specializes in obstetrics or gynecology is any individual (including a person other than a physician) who is authorized under applicable State law to provide obstetrical or gynecological care.

(B) *Obstetrical and gynecological care.* A group health plan or health insurance issuer described in paragraph (a)(3)(ii) of this section must treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (a)(3)(i)(A) of this section, by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(ii) *Application of paragraph.* A group health plan, or a health insurance issuer offering group health insurance coverage, is described in this paragraph (a)(3) if the plan or issuer—

(A) Provides coverage for obstetrical or gynecological care; and

(B) Requires the designation by a participant or beneficiary of a participating primary care provider.

(iii) *Construction.* Nothing in paragraph (a)(3)(i) of this section is to be construed to—

(A) Waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) Preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(iv) *Examples.* The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's family. Participant A, a female, requests a gynecological exam with Physician B, an in-network physician specializing in gynecological care. The group health plan requires prior authorization from A's designated primary care provider for the gynecological exam.

(ii) *Conclusion.* In this *Example 1,* the group health plan has violated the requirements of this paragraph (a)(3) because the plan requires prior authorization from A's primary care provider prior to obtaining gynecological services.

Example 2. (i) *Facts.* Same facts as *Example 1* except that A seeks gynecological services from C, an out-of-network provider.

(ii) *Conclusion.* In this *Example 2,* the group health plan has not violated the requirements of this paragraph (a)(3) by requiring prior authorization because C is not a participating health care provider.

Example 3. (i) *Facts.* Same facts as *Example 1* except that the group health plan only requires B to inform A's designated primary care physician of treatment decisions.

(ii) *Conclusion.* In this *Example 3,* the group health plan has not violated the requirements of this paragraph (a)(3) because A has direct access to B without prior authorization. The fact that the group health plan requires notification of treatment decisions to the designated primary care physician does not violate this paragraph (a)(3).

Example 4. (i) *Facts.* A group health plan requires each participant to designate a physician to serve as the primary care provider for the participant and the participant's

family. The group health plan requires prior authorization before providing benefits for uterine fibroid embolization.

(ii) *Conclusion*. In this *Example 4*, the plan requirement for prior authorization before providing benefits for uterine fibroid embolization does not violate the requirements of this paragraph (a)(3) because, though the prior authorization requirement applies to obstetrical services, it does not restrict access to any providers specializing in obstetrics or gynecology.

(4) *Notice of right to designate a primary care provider*—(i) *In general*. If a group health plan or health insurance issuer requires the designation by a participant or beneficiary of a primary care provider, the plan or issuer must provide a notice informing each participant of the terms of the plan or health insurance coverage regarding designation of a primary care provider and of the rights—

(A) Under paragraph (a)(1)(i) of this section, that any participating primary care provider who is available to accept the participant or beneficiary can be designated;

(B) Under paragraph (a)(2)(i) of this section, with respect to a child, that any participating physician who specializes in pediatrics can be designated as the primary care provider; and

(C) Under paragraph (a)(3)(i) of this section, that the plan may not require authorization or referral for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(ii) *Timing*. The notice described in paragraph (a)(4)(i) of this section must be included whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage.

(iii) *Model language*. The following model language can be used to satisfy the notice requirement described in paragraph (a)(4)(i) of this section:

(A) For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

[Name of group health plan or health insurance issuer] generally [requires/allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. [If the plan or health insurance coverage designates a primary care provider automatically, insert: Until you make this designation, [name of group health plan or health insurance issuer] designates one for you.] For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the [plan administrator or issuer] at [insert contact information].

(B) For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

For children, you may designate a pediatrician as the primary care provider.

(C) For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from [name of group health plan or issuer] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the [plan administrator or issuer] at [insert contact information].

(b) *Coverage of emergency services*—(1) *Scope*. If a group health plan, or a health insurance issuer offering group health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b).

(2) *General rules*. A plan or issuer subject to the requirements of this paragraph (b) must provide coverage for emergency services in the following manner—

(i) Without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis;

(ii) Without regard to whether the health care provider furnishing the emergency services is a participating

network provider with respect to the services;

(iii) If the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers;

(iv) If the emergency services are provided out of network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section; and

(v) Without regard to any other term or condition of the coverage, other than—

(A) The exclusion of or coordination of benefits;

(B) An affiliation or waiting period permitted under part 7 of ERISA, part A of title XXVII of the PHS Act, or chapter 100 of the Internal Revenue Code; or

(C) Applicable cost sharing.

(3) *Cost-sharing requirements*—(i) *Copayments and coinsurance.* Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant or beneficiary for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant or beneficiary if the services were provided in-network. However, a participant or beneficiary may be required to pay, in addition to the in-network cost sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i). A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits with respect to an emergency service in an amount equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (b)(3)(i)(B), and (b)(3)(i)(C) of this section (which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this paragraph (b)(3)(i)(A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this paragraph (b)(3)(i)(A) is disregarded.

(B) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary. The amount in this paragraph (b)(3)(i)(B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount in this paragraph (b)(3)(i)(B) for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant or beneficiary.

(ii) *Other cost sharing.* Any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to

emergency services provided out of network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-pocket maximum must apply to out-of-network emergency services.

(iii) *Examples*. The rules of this paragraph (b)(3) are illustrated by the following examples. In all of these examples, the group health plan covers benefits with respect to emergency services.

Example 1. (i) *Facts*. A group health plan imposes a 25% coinsurance responsibility on individuals who are furnished emergency services, whether provided in network or out of network. If a covered individual notifies the plan within two business days after the day an individual receives treatment in an emergency department, the plan reduces the coinsurance rate to 15%.

(ii) *Conclusion*. In this *Example 1*, the requirement to notify the plan in order to receive a reduction in the coinsurance rate does not violate the requirement that the plan cover emergency services without the need for any prior authorization determination. This is the result even if the plan required that it be notified before or at the time of receiving services at the emergency department in order to receive a reduction in the coinsurance rate.

Example 2. (i) *Facts*. A group health plan imposes a $60 copayment on emergency services without preauthorization, whether provided in-network or out-of-network. If emergency services are preauthorized, the plan waives the copayment, even if it later determines the medical condition was not an emergency medical condition.

(ii) *Conclusion*. In this *Example 2*, by requiring an individual to pay more for emergency services if the individual does not obtain prior authorization, the plan violates the requirement that the plan cover emergency services without the need for any prior authorization determination. (By contrast, if, to have the copayment waived, the plan merely required that it be notified rather than a prior authorization, then the plan would not violate the requirement that the plan cover emergency services without the need for any prior authorization determination.)

Example 3. (i) *Facts*. A group health plan covers individuals who receive emergency services with respect to an emergency medical condition from an out-of-network provider. The plan has agreements with in-network providers with respect to a certain emergency service. Each provider has agreed to provide the service for a certain amount. Among all the providers for the service: One has agreed to accept $85, two have agreed to accept $100, two have agreed to accept $110, three have agreed to accept $120, and one has agreed to accept $150. Under the agreement, the plan agrees to pay the providers 80% of the agreed amount, with the individual receiving the service responsible for the remaining 20%.

(ii) *Conclusion*. In this *Example 3*, the values taken into account in determining the median are $85, $100, $100, $110, $110, $120, $120, $120, and $150. Therefore, the median amount among those agreed to for the emergency service is $110, and the amount under paragraph (b)(3)(i)(A) of this section is 80% of $110 ($88).

Example 4. (i) *Facts*. Same facts as *Example 3*. Subsequently, the plan adds another provider to its network, who has agreed to accept $150 for the emergency service.

(ii) *Conclusion*. In this *Example 4*, the median amount among those agreed to for the emergency service is $115. (Because there is no one middle amount, the median is the average of the two middle amounts, $110 and $120.) Accordingly, the amount under paragraph (b)(3)(i)(A) of this section is 80% of $115 ($92).

Example 5. (i) *Facts*. Same facts as *Example 4*. An individual covered by the plan receives the emergency service from an out-of-network provider, who charges $125 for the service. With respect to services provided by out-of-network providers generally, the plan reimburses covered individuals 50% of the reasonable amount charged by the provider for medical services. For this purpose, the reasonable amount for any service is based on information on charges by all providers collected by a third party, on a zip-code-by-zip-code basis, with the plan treating charges at a specified percentile as reasonable. For the emergency service received by the individual, the reasonable amount calculated using this method is $116. The amount that would be paid under Medicare for the emergency service, excluding any copayment or coinsurance for the service, is $80.

(ii) *Conclusion*. In this *Example 5*, the plan is responsible for paying $92.80, 80% of $116. The median amount among those agreed to for the emergency service is $115 and the amount the plan would pay is $92 (80% of $115); the amount calculated using the same method the plan uses to determine payments for out-of-network services—$116—excluding the in-network 20% coinsurance, is $92.80; and the Medicare payment is $80. Thus, the greatest amount is $92.80. The individual is responsible for the remaining $32.20 charged by the out-of-network provider.

Example 6. (i) *Facts*. Same facts as *Example 5*. The group health plan generally imposes a

$250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a $500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted $260 of covered claims prior to receiving the emergency service out of network.

(ii) *Conclusion*. In this *Example 6*, the plan is not responsible for paying anything with respect to the emergency service furnished by the out-of-network provider because the covered individual has not satisfied the higher deductible that applies generally to all health care provided out of network. However, the amount the individual is required to pay is credited against the deductible.

(4) *Definitions*. The definitions in this paragraph (b)(4) govern in applying the provisions of this paragraph (b).

(i) *Emergency medical condition*. The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(ii) *Emergency services*. The term *emergency services* means, with respect to an emergency medical condition—

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(iii) *Stabilize*. The term *to stabilize*, with respect to an emergency medical condition (as defined in paragraph (b)(4)(i) of this section) has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) *Effective/applicability date*. The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 54.9815–1251T for determining the application of this section to grandfathered health plans (providing that these rules regarding patient protections do not apply to grandfathered health plans).

(d) *Expiration date*. This section expires on June 21, 2013.

[T.D. 9491, 75 FR 37225, June 28, 2010]

§ 54.9815–2719T Internal claims and appeals and external review processes (temporary).

(a) *Scope and definitions*—(1) *Scope*. This section sets forth requirements with respect to internal claims and appeals and external review processes for group health plans and health insurance issuers that are not grandfathered health plans under § 54.9815–1251T. Paragraph (b) of this section provides requirements for internal claims and appeals processes. Paragraph (c) of this section sets forth rules governing the applicability of State external review processes. Paragraph (d) of this section sets forth a Federal external review process for plans and issuers not subject to an applicable State external review process. Paragraph (e) of this section prescribes requirements for ensuring that notices required to be provided under this section are provided in a culturally and linguistically appropriate manner. Paragraph (f) of this section describes the authority of the Secretary to deem certain external review processes in existence on March 23, 2010 as in compliance with paragraph (c) or (d) of this section. Paragraph (g) of this section sets forth the applicability date for this section.

(2) *Definitions*. For purposes of this section, the following definitions apply—

(i) *Adverse benefit determination*. An *adverse benefit determination* means an adverse benefit determination as defined in 29 CFR 2560.503–1, as well as

any rescission of coverage, as described in § 54.9815–2712T(a)(2) (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time).

(ii) *Appeal (or internal appeal).* An *appeal* or *internal appeal* means review by a plan or issuer of an adverse benefit determination, as required in paragraph (b) of this section.

(iii) *Claimant. Claimant* means an individual who makes a claim under this section. For purposes of this section, references to claimant include a claimant's authorized representative.

(iv) *External review. External review* means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to an applicable State external review process described in paragraph (c) of this section or the Federal external review process of paragraph (d) of this section.

(v) *Final internal adverse benefit determination.* A *final internal adverse benefit determination* means an adverse benefit determination that has been upheld by a plan or issuer at the completion of the internal appeals process applicable under paragraph (b) of this section (or an adverse benefit determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of paragraph (b)(2)(ii)(F) of this section).

(vi) *Final external review decision.* A *final external review decision,* as used in paragraph (d) of this section, means a determination by an independent review organization at the conclusion of an external review.

(vii) *Independent review organization* (or *IRO*). An *independent review organization* (or *IRO*) means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations pursuant to paragraph (c) or (d) of this section.

(viii) *NAIC Uniform Model Act.* The *NAIC Uniform Model Act* means the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners in place on July 23, 2010.

(b) *Internal claims and appeals process*—(1) *In general.* A group health plan and a health insurance issuer offering group health insurance coverage must implement an effective internal claims and appeals process, as described in this paragraph (b).

(2) *Requirements for group health plans and group health insurance issuers.* A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements of this paragraph (b)(2). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the internal claims and appeals process of this paragraph (b)(2), then the obligation to comply with this paragraph (b)(2) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(i) *Minimum internal claims and appeals standards.* A group health plan and a health insurance issuer offering group health insurance coverage must comply with all the requirements applicable to group health plans under 29 CFR 2560.503–1, except to the extent those requirements are modified by paragraph (b)(2)(ii) of this section. Accordingly, under this paragraph (b), with respect to health insurance coverage offered in connection with a group health plan, the group health insurance issuer is subject to the requirements in 29 CFR 2560.503–1 to the same extent as the group health plan.

(ii) *Additional standards.* In addition to the requirements in paragraph (b)(2)(i) of this section, the internal claims and appeals processes of a group health plan and a health insurance issuer offering group health insurance coverage must meet the requirements of this paragraph (b)(2)(ii).

(A) *Clarification of meaning of adverse benefit determination.* For purposes of this paragraph (b)(2), an ''adverse benefit determination'' includes an adverse benefit determination as defined in paragraph (a)(2)(i) of this section. Accordingly, in complying with 29 CFR 2560.503–1, as well as the other provisions of this paragraph (b)(2), a plan or issuer must treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular

benefit at that time) as an adverse benefit determination. (Rescissions of coverage are subject to the requirements of § 54.9815–2712T.)

(B) *Expedited notification of benefit determinations involving urgent care.* The requirements of 29 CFR 2560.503–1(f)(2)(i) (which generally provide, among other things, in the case of urgent care claims for notification 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) continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503–1(m)(1), as determined by the attending provider, and the plan or issuer shall defer to such determination of the attending provider.

(C) *Full and fair review.* A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. Specifically, in addition to complying with the requirements of 29 CFR 2560.503–1(h)(2)—

(*1*) The plan or issuer must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date; and

(*2*) Before the plan or issuer can issue a final internal adverse benefit determination based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided under 29 CFR 2560.503–1(i) to give the claimant a reasonable opportunity to respond prior to that date.

(D) *Avoiding conflicts of interest.* In addition to the requirements of 29 CFR 2560.503–1(b) and (h) regarding full and fair review, the plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(E) *Notice.* A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner (as described in paragraph (e) of this section) that complies with the requirements of 29 CFR 2560.503–1(g) and (j). The plan and issuer must also comply with the additional requirements of this paragraph (b)(2)(ii)(E).

(*1*) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(*2*) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under this paragraph (b) or an external review under paragraphs (c) and (d) of this section.

(*3*) The plan and issuer must ensure that the reason or reasons for the adverse benefit determination or final internal adverse benefit determination

includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(*4*) The plan and issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(*5*) The plan and issuer must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

(F) *Deemed exhaustion of internal claims and appeals processes*—(*1*) In the case of a plan or issuer that fails to adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), except as provided in paragraph (b)(2)(ii)(F)(*2*) of this section. Accordingly, the claimant may initiate an external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(*2*) Notwithstanding paragraph (b)(2)(ii)(F)(*1*) of this section, the internal claims and appeals process of this paragraph (b) will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The claimant may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this paragraph (b) to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under paragraph (b)(2)(ii)(F)(*1*) of this section on the basis that the plan met the standards for the exception under this paragraph (b)(2)(ii)(F)(*2*), the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon claimant's receipt of such notice.

(iii) *Requirement to provide continued coverage pending the outcome of an appeal.* A plan and issuer subject to the requirements of this paragraph (b)(2) are required to provide continued coverage pending the outcome of an appeal. For this purpose, the plan and issuer must comply with the requirements of 29 CFR 2560.503–1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

(c) *State standards for external review*—(1) *In general.* (i) If a State external review process that applies to and is binding on a health insurance issuer offering group health insurance coverage includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the issuer must comply with the applicable State external review process and is not required to comply

with the Federal external review process of paragraph (d) of this section. In such a case, to the extent that benefits under a group health plan are provided through health insurance coverage, the group health plan is not required to comply with either this paragraph (c) or the Federal external review process of paragraph (d) of this section.

(ii) To the extent that a group health plan provides benefits other than through health insurance coverage (that is, the plan is self-insured) and is subject to a State external review process that applies to and is binding on the plan (for example, is not preempted by ERISA) and the State external review process includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan must comply with the applicable State external review process and is not required to comply with the Federal external review process of paragraph (d) of this section.

(iii) If a plan or issuer is not required under paragraph (c)(1)(i) or (c)(1)(ii) of this section to comply with the requirements of this paragraph (c), then the plan or issuer must comply with the Federal external review process of paragraph (d) of this section, except to the extent, in the case of a plan, the plan is not required under paragraph (c)(1)(i) of this section to comply with paragraph (d) of this section.

(2) *Minimum standards for State external review processes.* An applicable State external review process must meet all the minimum consumer protections in this paragraph (c)(2). The Department of Health and Human Services will determine whether State external review processes meet these requirements.

(i) The State process must provide for the external review of adverse benefit determinations (including final internal adverse benefit determinations) by issuers (or, if applicable, plans) that are based on the issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

(ii) The State process must require issuers (or, if applicable, plans) to provide effective written notice to claimants of their rights in connection with an external review for an adverse benefit determination.

(iii) To the extent the State process requires exhaustion of an internal claims and appeals process, exhaustion must be unnecessary where the issuer (or, if applicable, the plan) has waived the requirement, the issuer (or the plan) is considered to have exhausted the internal claims and appeals process under applicable law (including by failing to comply with any of the requirements for the internal appeal process, as outlined in paragraph (b)(2) of this section), or the claimant has applied for expedited external review at the same time as applying for an expedited internal appeal.

(iv) The State process provides that the issuer (or, if applicable, the plan) against which a request for external review is filed must pay the cost of the IRO for conducting the external review. Notwithstanding this requirement, the State external review process may require a nominal filing fee from the claimant requesting an external review. For this purpose, to be considered nominal, a filing fee must not exceed $25, it must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review, it must be waived if payment of the fee would impose an undue financial hardship, and the annual limit on filing fees for any claimant within a single plan year must not exceed $75.

(v) The State process may not impose a restriction on the minimum dollar amount of a claim for it to be eligible for external review. Thus, the process may not impose, for example, a $500 minimum claims threshold.

(vi) The State process must allow at least four months after the receipt of a notice of an adverse benefit determination or final internal adverse benefit determination for a request for an external review to be filed.

(vii) The State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no

event selected by the issuer, plan, or the individual.

(viii) The State process must provide for maintenance of a list of approved IROs qualified to conduct the external review based on the nature of the health care service that is the subject of the review. The State process must provide for approval only of IROs that are accredited by a nationally recognized private accrediting organization.

(ix) The State process must provide that any approved IRO has no conflicts of interest that will influence its independence. Thus, the IRO may not own or control, or be owned or controlled by a health insurance issuer, a group health plan, the sponsor of a group health plan, a trade association of plans or issuers, or a trade association of health care providers. The State process must further provide that the IRO and the clinical reviewer assigned to conduct an external review may not have a material professional, familial, or financial conflict of interest with the issuer or plan that is the subject of the external review; the claimant (and any related parties to the claimant) whose treatment is the subject of the external review; any officer, director, or management employee of the issuer; the plan administrator, plan fiduciaries, or plan employees; the health care provider, the health care provider's group, or practice association recommending the treatment that is subject to the external review; the facility at which the recommended treatment would be provided; or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended.

(x) The State process allows the claimant at least five business days to submit to the IRO in writing additional information that the IRO must consider when conducting the external review and it requires that the claimant is notified of the right to do so. The process must also require that any additional information submitted by the claimant to the IRO must be forwarded to the issuer (or, if applicable, the plan) within one business day of receipt by the IRO.

(xi) The State process must provide that the decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(xii) The State process must require, for standard external review, that the IRO provide written notice to the claimant and the issuer (or, if applicable, the plan) of its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) within no more than 45 days after the receipt of the request for external review by the IRO.

(xiii) The State process must provide for an expedited external review if the adverse benefit determination (or final internal adverse benefit determination) concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility; or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of the claimant or jeopardize the claimant's ability to regain maximum function. As expeditiously as possible but within no more than 72 hours after the receipt of the request for expedited external review by the IRO, the IRO must make its decision to uphold or reverse the adverse benefit determination (or final internal adverse benefit determination) and notify the claimant and the issuer (or, if applicable, the plan) of the determination. If the notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours after the date of the notice of the decision.

(xiv) The State process must require that issuers (or, if applicable, plans) include a description of the external review process in or attached to the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants, beneficiaries, or enrollees, substantially similar to what is set forth in section 17 of the NAIC Uniform Model Act.

(xv) The State process must require that IROs maintain written records and make them available upon request to the State, substantially similar to what is set forth in section 15 of the NAIC Uniform Model Act.

(xvi) The State process follows procedures for external review of adverse benefit determinations (or final internal adverse benefit determinations) involving experimental or investigational treatment, substantially similar to what is set forth in section 10 of the NAIC Uniform Model Act.

(3) *Transition period for external review processes.* (i) Through December 31, 2011, an applicable State external review process applicable to a health insurance issuer or group health plan is considered to meet the requirements of PHS Act section 2719(b). Accordingly, through December 31, 2011, an applicable State external review process will be considered binding on the issuer or plan (in lieu of the requirements of the Federal external review process). If there is no applicable State external review process, the issuer or plan is required to comply with the requirements of the Federal external review process in paragraph (d) of this section.

(ii) For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2012, the Federal external review process will apply unless the Department of Health and Human Services determines that a State law meets all the minimum standards of paragraph (c)(2) of this section.

(d) *Federal external review process.* A plan or issuer not subject to an applicable State external review process under paragraph (c) of this section must provide an effective Federal external review process in accordance with this paragraph (d) (except to the extent, in the case of a plan, the plan is described in paragraph (c)(1)(i) of this section as not having to comply with this paragraph (d)). In the case of health insurance coverage offered in connection with a group health plan, if either the plan or the issuer complies with the Federal external review process of this paragraph (d), then the obligation to comply with this paragraph (d) is satisfied for both the plan and the issuer with respect to the health insurance coverage.

(1) *Scope*—(i) *In general.* Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal external review process established pursuant to this paragraph (d) applies to any adverse benefit determination or final internal adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

(ii) *Suspension of general rule.* Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which external review has not been initiated before September 20, 2011, the Federal external review process established pursuant to this paragraph (d) applies only to:

(A) An adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

(B) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(iii) *Examples.* The rules of paragraph (d)(1)(ii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides coverage for 30 physical therapy visits generally. After the 30th visit, coverage is provided only if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Individual *A* seeks coverage for a 31st physical therapy visit. *A*'s health care provider submits a treatment plan for approval, but it is not approved by the plan, so coverage for the 31st visit is not preauthorized. With respect to the 31st visit, *A* receives a notice of final internal adverse benefit determination stating that the maximum visit limit is exceeded.

(ii) *Conclusion.* In this *Example 1,* the plan's denial of benefits is based on medical necessity and involves medical judgment. Accordingly, the claim is eligible for external review during the suspension period under paragraph (d)(1)(ii) of this section. Moreover, the plan's notification of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because it fails to make clear that the plan will pay for more than 30 visits if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Accordingly, the notice of final internal adverse benefit determination should refer to the plan provision governing the 31st visit and should describe the plan's standard for medical necessity, as well as how the treatment fails to meet the plan's standard.

Example 2. (i) *Facts.* A group health plan does not provide coverage for services provided out of network, unless the service cannot effectively be provided in network. Individual *B* seeks coverage for a specialized medical procedure from an out-of-network provider because *B* believes that the procedure cannot be effectively provided in network. *B* receives a notice of final internal adverse benefit determination stating that the claim is denied because the provider is out-of-network.

(ii) *Conclusion.* In this *Example 2,* the plan's denial of benefits is based on whether a service can effectively be provided in network and, therefore, involves medical judgment. Accordingly, the claim is eligible for external review during the suspension period under paragraph (d)(1)(ii) of this section. Moreover, the plan's notice of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because the plan does provide benefits for services on an out-of-network basis if the services cannot effectively be provided in network. Accordingly, the notice of final internal adverse benefit determination is required to refer to the exception to the out-of-network exclusion and should describe the plan's standards for determining effectiveness of services, as well as how services available to the claimant within the plan's network meet the plan's standard for effectiveness of services.

(2) *External review process standards.* The Federal external review process established pursuant to this paragraph (d) will be similar to the process set forth in the NAIC Uniform Model Act and will meet standards issued by the Secretary. These standards will comply with all of the requirements described in this paragraph (d)(2).

(i) These standards will describe how a claimant initiates an external review, procedures for preliminary reviews to determine whether a claim is eligible for external review, minimum qualifications for IROs, a process for approving IROs eligible to be assigned to conduct external reviews, a process for random assignment of external reviews to approved IROs, standards for IRO decision-making, and rules for providing notice of a final external review decision.

(ii) These standards will provide an expedited external review process for—

(A) An adverse benefit determination, if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under paragraph (b) of this section would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal under paragraph (b) of this section; or

(B) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review pursuant to paragraph (d)(3) of this section would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the claimant received emergency services, but has not been discharged from a facility.

(iii) With respect to claims involving experimental or investigational treatments, these standards will also provide additional consumer protections to ensure that adequate clinical and scientific experience and protocols are taken into account as part of the external review process.

(iv) These standards will provide that an external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

(v) These standards may establish external review reporting requirements for IROs.

(vi) These standards will establish additional notice requirements for plans and issuers regarding disclosures to participants and beneficiaries describing the Federal external review procedures (including the right to file a request for an external review of an adverse benefit determination or a final internal adverse benefit determination in the summary plan description, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage it provides to participants or beneficiaries).

(vii) These standards will require plans and issuers to provide information relevant to the processing of the external review, including, but not limited to, the information considered and relied on in making the adverse benefit determination or final internal adverse benefit determination.

(e) *Form and manner of notice*—(1) *In general*. For purposes of this section, a group health plan and a health insurance issuer offering group health insurance coverage are considered to provide relevant notices in a culturally and linguistically appropriate manner if the plan or issuer meets all the requirements of paragraph (e)(2) of this section with respect to the applicable non-English languages described in paragraph (e)(3) of this section.

(2) *Requirements*—(i) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(ii) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(iii) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

(3) *Applicable non-English language*. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

(f) *Secretarial authority*. The Secretary may determine that the external review process of a group health plan or health insurance issuer, in operation as of March 23, 2010, is considered in compliance with the applicable process established under paragraph (c) or (d) of this section if it substantially meets the requirements of paragraph (c) or (d) of this section, as applicable.

(g) *Applicability/effective date*. The provisions of this section apply for plan years beginning on or after September 23, 2010. See §54.9815–1251T for determining the application of this section to grandfathered health plans (providing that these rules regarding internal claims and appeals and external review processes do not apply to grandfathered health plans).

(h) *Expiration date.* The applicability of this section expires on July 22, 2013 or on such earlier date as may be provided in final regulations or other action published in the FEDERAL REGISTER.

[T.D. 9494, 75 FR 43350, July 23, 2010, as amended by T.D. 9532, 76 FR 37228, June 24, 2011]

§ 54.9831–1 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* (1) Subject to paragraph (b)(2) of this section, the requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9811–1, 54.9812–1T, and 54.9833–1 do not apply to any 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) The exception of paragraph (b)(1) of this section does not apply with respect to the following requirements:

(i) Section 54.9801–3(b)(6).

(ii) Section 54.9802–1(b), as such paragraph applies with respect to genetic information as a health factor.

(iii) Section 54.9802–1(c), as such paragraph applies with respect to genetic information as a health factor.

(iv) Section 54.9802–1(e), as such paragraph applies with respect to genetic information as a health factor.

(v) Section 54.9802–3T(b).

(vi) Section 54.9802–3T(c).

(vii) Section 54.9802–3T(d).

(viii) Section 54.9802–3T(e).

(c) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–2, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan in relation to its provision of the benefits described in paragraph (c)(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 coverage;

(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 coverage;

(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 a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially

all of which are for treatment of the eye.

(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 services, as defined in section 7702B(c)(1), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(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 indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(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.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental

only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example*, the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (*See* 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of Title I of ERISA and Title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

[T.D. 9166, 69 FR 78746, Dec. 30, 2004; 70 FR 21146, Apr. 25, 2005, as amended by T.D. 9299, 71 FR 75057, Dec. 13, 2006; T.D. 9427, 73 FR 62422, Oct. 20, 2008; T.D. 9464, 74 FR 51678, Oct. 7, 2009]

§ 54.9833–1 Effective dates.

Sections 54.9801–1 through 54.9801–6, 54.9831–1, and this section are applicable for plan years beginning on or after July 1, 2005.

[T.D. 9166, 69 FR 78746, Dec. 30, 2004]

PART 55—EXCISE TAX ON REAL ESTATE INVESTMENT TRUSTS AND REGULATED INVESTMENT COMPANIES

Subpart A—Excise Tax on Real Estate Investment Trusts

Sec.
55.4981–1 Imposition of excise tax on certain real estate investment trust taxable income not distributed during the taxable year; taxable years ending on or before January 1, 1987.
55.4981–2 Imposition of excise tax with respect to certain undistributed income of real estate investment trusts; calendar years beginning after December 31, 1986.

Subpart B—Excise Tax on Regulated Investment Companies

55.4982–1 Imposition of excise tax on undistributed income of regulated investment companies.

Subpart C—Procedure and Administration

55.6001–1 Notice or regulations requiring records, statements, and special returns.
55.6011–1 General requirement of return, statement, or list.
55.6060–1 Reporting requirements for tax return preparers.
55.6061–1 Signing of returns and other documents.
55.6065–1 Verification of returns.
55.6071–1 Time for filing returns.
55.6081–1 Automatic extension of time for filing a return due under Chapter 44.
55.6091–1 Place for filing Chapter 44 tax returns.
55.6091–2 Exceptional cases.