§ 2400.9 Procedures for appealing.

(a) Submission of appeal—(1) If a request to inspect, copy or amend a record is denied, in whole or in part, or if no determination is made within the period prescribed by this part, then the requester may appeal to the Chairman, Attn: Privacy Appeal, OSHRC, One Lafayette Centre, 1120–20th Street, NW., Ninth Floor, Washington, DC 20036–3457.

(2) The requester shall submit his appeal in writing within thirty (30) days of the date of denial, or within ninety (90) days of such request if the appeal is from a failure of the Privacy Officer to make a determination. The letter of appeal should include, as applicable:

(i) Reasonable identification of the record to which access was sought or the amendment of which was requested.

(ii) A statement of the OSHRC action or failure to act being appealed and the relief sought.

(iii) A copy of the request, the notification of denial and any other related correspondence.

(b) Final decisions. The Chairman shall make his final decision not later than thirty (30) working days from the date of the request, unless he extends the time for good cause to be shown by him but not to exceed ninety (90) days from the date of the request. Any record found on appeal to be incomplete, inaccurate, irrelevant, or untimely, shall within thirty (30) working days of the date of such findings be appropriately amended.

(c) Decision requirements. The decision of the Chairman constitutes the final decision of OSHRC on the right of the requester to inspect, copy, change or update a record. The decision on the appeal shall be in writing and, in the event of a denial, shall set forth the reasons for such denial and state the individual’s right to obtain judicial review in a district court of the United States. An indexed file of the agency’s decisions on appeal shall be maintained by the Privacy Officer.

(d) Submission of statement of disagreement. If the final decision does not satisfy the requester, then any statement of reasonable length, provided by that individual, setting forth a position regarding the disputed information, shall be accepted and included in the relevant record.

§ 2400.10 Schedule of fees.

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

(b) Reproduction—(1) For the fees associated with reproduction of records, refer to Appendix A to part 2201, Schedule of Fees.

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

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

PARTS 2401–2499 [RESERVED]
CHAPTER XXV—EMPLOYEE BENEFITS SECURITY ADMINISTRATION, DEPARTMENT OF LABOR


SUBCHAPTER A—GENERAL

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2500–2508</td>
<td>[Reserved]</td>
</tr>
<tr>
<td>2509</td>
<td>Interpretive bulletins relating to the Employee Retirement Income Security Act of 1974</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2510</td>
<td>Definition of terms used in subchapters C, D, E, F, G, AND L of this chapter</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2520</td>
<td>Rules and regulations for reporting and disclosure</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2530</td>
<td>Rules and regulations for minimum standards for employee pension benefit plans</td>
</tr>
</tbody>
</table>

SUBCHAPTER E [RESERVED]

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2550</td>
<td>Rules and regulations for fiduciary responsibility</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Part</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2560</td>
<td>Rules and regulations for administration and enforcement</td>
</tr>
<tr>
<td>2570</td>
<td>Procedural regulations under the Employee Retirement Income Security Act</td>
</tr>
<tr>
<td>Part</td>
<td>Title</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2571</td>
<td>Procedural regulations for administration and enforcement under the</td>
</tr>
<tr>
<td></td>
<td>Employee Retirement Income Security Act</td>
</tr>
<tr>
<td>2575</td>
<td>Adjustment of civil penalties under ERISA Title I</td>
</tr>
<tr>
<td>2578</td>
<td>Rules and regulations for abandoned plans</td>
</tr>
<tr>
<td></td>
<td>SUBCHAPTER H [RESERVED]</td>
</tr>
<tr>
<td></td>
<td>SUBCHAPTER I—TEMPORARY BONDING RULES UNDER THE EMPLOYEE RETIREMENT</td>
</tr>
<tr>
<td></td>
<td>INCOME SECURITY ACT OF 1974</td>
</tr>
<tr>
<td>2580</td>
<td>Temporary bonding rules</td>
</tr>
<tr>
<td></td>
<td>SUBCHAPTER J—FIDUCIARY RESPONSIBILITY UNDER THE FEDERAL EMPLOYEES'</td>
</tr>
<tr>
<td></td>
<td>RETIREMENT SYSTEM ACT OF 1986</td>
</tr>
<tr>
<td>2582</td>
<td>Rules and regulations for fiduciary responsibility</td>
</tr>
<tr>
<td>2584</td>
<td>Rules and regulations for the allocation of fiduciary responsibility</td>
</tr>
<tr>
<td></td>
<td>SUBCHAPTER K—ADMINISTRATION AND ENFORCEMENT UNDER THE FEDERAL</td>
</tr>
<tr>
<td></td>
<td>EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986</td>
</tr>
<tr>
<td>2589</td>
<td>Rules and regulations for administration and enforcement</td>
</tr>
<tr>
<td></td>
<td>SUBCHAPTER L—GROUP HEALTH PLANS</td>
</tr>
<tr>
<td>2590</td>
<td>Rules and regulations for group health plans</td>
</tr>
<tr>
<td>2591-2599</td>
<td>[Reserved]</td>
</tr>
</tbody>
</table>
SUBCHAPTER A—GENERAL

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

Sec. 2509.08–1 Supplemental guidance relating to fiduciary responsibility in considering economically targeted investments.

This Interpretive Bulletin sets forth the Department of Labor’s interpretation of sections 403 and 404 of the Employee Retirement Income Security Act of 1974 (ERISA), as applied to employee benefit plan investments in “economically targeted investments,” that is, investments selected for the economic benefits they create apart from their investment return to the employee benefit plan. The guidance set forth in this interpretive bulletin modifies and supersedes the guidance set forth in interpretive bulletin 94–1 (29 CFR 2509.94–1).

ERISA requires that a fiduciary act solely in the interest of the plan’s participants and beneficiaries and for the exclusive purpose of providing benefits to their participants and beneficiaries. The Act specifically states, in relevant part, that:

• “[A]ssets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries.”

• “[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries.”

ERISA’s plain text thus establishes a clear rule that in the course of discharging their duties, fiduciaries may never subordinate the economic interests of the plan to unrelated objectives, and may not select investments on the basis of any factor outside the economic interest of the plan except in very limited circumstances enumerated below.

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

\[1\] Sec. 403(c)(1), 29 U.S.C.A. 1103(c)(1).
action plays (in terms of such factors as diversification, liquidity and risk/return characteristics) with respect to that portion of the plan’s investment portfolio within the scope of the fiduciary’s responsibility.

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

ERISA’s plain text does not permit fiduciaries to make investment decisions on the basis of any factor other than the economic interest of the plan. Situations may arise, however, in which two or more investment alternatives are of equal economic value to a plan. The Department has recognized in past guidance that under these limited circumstances, fiduciaries can choose between the investment alternatives on the basis of a factor other than the economic interest of the plan. The Department has interpreted the statute to permit this selection because (1) ERISA requires fiduciaries to invest plan assets and to make choices between investment alternatives, (2) ERISA does not itself specifically provide a basis for making the investment choice in this circumstance, and (3) the economic interests of the plan are fully protected by the fact that the available investment alternatives are, from the plan’s perspective, economically indistinguishable.

Given the significance of ERISA’s requirement that fiduciaries act “solely in the interest of participants and beneficiaries,” the Department believes that, before selecting an economically targeted investment, fiduciaries must have first concluded that the alternative options are truly equal, taking into account a quantitative and qualitative analysis of the economic impact on the plan. ERISA’s fiduciary standards expressed in sections 403 and 404 do not permit fiduciaries to invest plan assets based on factors outside the economic interests of the plan until they have concluded, based on economic factors, that alternative investments are equal. A less rigid rule would allow fiduciaries to act on the basis of factors outside the economic interest of the plan in situations where reliance on those factors might compromise or subordinate the interests of plan participants and their beneficiaries. The Department rejects a construction of ERISA that would render the Act’s tight limits on the use of plan assets illusory, and that would permit plan fiduciaries to expend ERISA trust assets to promote myriad public policy preferences.3

A plan fiduciary’s analysis is required to comply with, but is not necessarily limited to, the requirements set forth in 29 CFR 2550.404a–1(b). In evaluating the plan portfolio, as well as portions of the portfolio, the fiduciary is required to examine the level of diversification, degree of liquidity, and the potential risk/return in comparison with available alternative investments. The same type of analysis must also be applied when choosing between investment alternatives. Potential investments should be compared to other investments that would fill a similar role in the portfolio with regard to diversification, liquidity, and risk/return.

In light of the rigorous requirements established by ERISA, the Department believes that fiduciaries who rely on factors outside the economic interests of the plan in making investment choices and subsequently find their decision challenged will rarely be able to demonstrate compliance with ERISA absent a written record demonstrating that a contemporaneous economic analysis showed that the investment alternatives were of equal value.

Examples:

A plan owns an interest in a limited partnership that is considering investing in a company that competes with the plan sponsor. The fiduciaries may not replace the limited partnership investment with another investment based on this fact unless they prudently determine that a replacement investment is economically equal or superior to the limited partnership investment and would not adversely affect the plan’s investment portfolio, taking into account factors including diversification, liquidity, risk and expected return. The competition of the limited partnership with the plan sponsor is a factor outside the economic interests of the plan, and thus cannot be considered unless an alternative investment is equal or superior to the limited partnership.

A multiemployer plan covering employees in a metropolitan area’s construction industry wants to invest in a large loan for a construction project located in the same area because it will create local jobs. The plan has taken steps to ensure that the loan poses no prohibited transaction issues. The loan carries a return fully commensurate with the risk of nonpayment. Moreover, the loan’s expected return is equal to or greater than construction loans of similar quality that are available to the plan. However, the plan

3 See letters from the Department of Labor to Jonathan Hiatt dated May 3, 2005; to Thomas Donahue dated December 21, 2007 (A.O. 2007–06A); and to David Chavern dated June 27, 2008 (A.O. 2008–03A).
Employee Benefits Security Admin., Labor § 2509.08–2

has already made several other loans for construction projects in the same metropolitan area, and this loan could create a risk of large losses to the plan’s portfolio due to lack of diversification. The fiduciaries may not choose this investment on the basis of the local job creation factor because, due to lack of diversification, the investment is not of equal economic value to the plan.

A plan is considering an investment in a bond to finance affordable housing for people in the local community. The bond provides a return at least as favorable to the plan as other bonds with the same risk rating. However, the bond’s size and lengthy duration raises a potential risk regarding the plan’s ability to meet its predicted liquidity needs. Other available bonds under consideration by the plan do not pose this same risk. The return on the bond, although equal to or greater than the alternatives, would not be sufficient to offset the additional risk for the plan created by the role that this bond would play in the plan’s portfolio. The plan’s fiduciaries may not make this investment based on factors outside the economic interest of the plan because it is not of equal or greater economic value to other investment alternatives.

A plan sponsor adopts an investment policy that favors plan investment in companies meeting certain environmental criteria (so-called “green” companies). In carrying out the policy, the plan’s fiduciaries may not simply consider investments only in green companies. They must consider all investments that meet the plan’s prudent financial criteria. The fiduciaries may apply the investment policy to eliminate a company from consideration only if they appropriately determine that other available investments provide equal or better returns at the same or lower risks, and would play the same role in the plan’s portfolio.

A collective investment fund, which holds assets of several plans, is designed to invest in commercial real estate constructed or renovated with union labor. Fiduciaries of plans that invest in the fund must determine that the fund’s overall risk and return characteristics are as favorable, or more favorable, to the plans as other available investment alternatives that would play a similar role in their plans’ portfolios. The fund’s managers may select investments constructed or improved with union labor, after an economic analysis indicates that these investment options are equal or superior to their alternatives. The managers will best be able to justify their investment choice by recording their analysis in writing. However, if real estate investments that satisfy both ERISA’s fiduciary requirements and the union labor criterion are unavailable, the fund managers may have to select investments without regard to the union labor criterion.

[73 FR 61735, Oct. 17, 2008]

§ 2509.08–2 Interpretive bulletin relating to the exercise of shareholder rights and written statements of investment policy, including proxy voting policies or guidelines.

This interpretive bulletin sets forth the Department of Labor’s (the Department) interpretation of sections 402, 403 and 404 of the Employee Retirement Income Security Act of 1974 (ERISA) as those sections apply to voting of proxies on securities held in employee benefit plan investment portfolios and the maintenance of and compliance with statements of investment policy, including proxy voting policy. In addition, this interpretive bulletin provides guidance on the appropriateness under ERISA of active monitoring of corporate management by plan fiduciaries. The guidance set forth in this interpretive bulletin modifies and supersedes the guidance set forth in interpretive bulletin 94–2 (29 CFR 2509.94–2).

(1) Proxy Voting

The fiduciary act of managing plan assets that are shares of corporate stock includes the management of voting rights appurtenant to those shares of stock. 1 As a result, the responsibility for voting or deciding not to vote proxies lies exclusively with the plan trustee except to the extent that either (1) the trustee is subject to the direction of a named fiduciary pursuant to ERISA Sec. 403(a)(1); or (2) the power to manage, acquire or dispose of the relevant assets has been delegated by a named fiduciary to one or more investment managers pursuant to ERISA Sec. 403(a)(2). Where the authority to manage plan assets has been delegated to an investment manager pursuant to Sec. 403(a)(2), no person other than the investment manager has authority to make voting decisions for proxies appurtenant to such plan assets except to the extent that the named fiduciary has reserved to itself (or to another named fiduciary so authorized by the plan document) the right to direct a plan trustee regarding the voting of proxies. In this regard, a named fiduciary, in delegating investment management authority to an investment manager, could reserve to itself the right to direct a trustee with respect to the voting of all proxies or reserve to itself the right to direct a trustee as to the voting

1 See letter from the Department of Labor to Helmut Fandl, Chairman of the Retirement Board of Avon Products, Inc., dated February 23, 1988.
§ 2509.08–2  29 CFR Ch. XXV (7–1–15 Edition)

of only those proxies relating to specified assets or issues.

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

The fiduciary duties described at ERISA Sec. 404(a)(1)(A) and (B), require that, in voting proxies, regardless of whether the vote is made pursuant to a statement of investment policy, the responsible fiduciary shall consider only those factors that relate to the economic value of the plan’s investment and shall not subordinate the interests of the participants and beneficiaries in their retirement income to unrelated objectives. Votes shall only be cast in accordance with a plan’s economic interests. If the responsible fiduciary reasonably determines that the cost of voting (including the cost of research, if necessary, to determine how to vote) is likely to exceed the expected economic benefits of voting, or if the exercise of voting results in the imposition of unwarranted trading or other restrictions, the fiduciary has an obligation to refrain from voting.2 In making this determination, objectives, considerations, and economic effects unrelated to the plan’s economic interests cannot be considered. The fiduciary’s duties under ERISA Sec. 404(a)(1)(A) and (B) also require that the named fiduciary appointing an investment manager periodically monitor the activities of the investment manager with respect to the management of plan assets, including decisions made and actions taken by the investment manager with regard to proxy voting decisions. The named fiduciary must carry out this responsibility solely in the participants’ and beneficiaries’ interest in the economic value of the plan assets and without regard to the fiduciary’s relationship to the plan sponsor.

It is the view of the Department that compliance with the duty to monitor necessitates proper documentation of the activities that are subject to monitoring. Thus, the investment manager or other responsible fiduciary would be required to maintain accurate records as to proxy voting decisions, including, where appropriate, cost-benefit analyses.3 Moreover, if the named fiduciary is to be able to carry out its responsibilities under ERISA Sec. 404(a) in determining whether the investment manager is fulfilling its fiduciary obligations in investing plans assets in a manner that justifies the continuation of the management appointment, the proxy voting records must enable the named fiduciary to review not only the investment manager’s voting procedure with respect to plan-owned stock, but also to review the actions taken in individual proxy voting situations.

The fiduciary obligations of prudence and loyalty to plan participants and beneficiaries require the responsible fiduciary to vote proxies on issues that may affect the economic value of the plan’s investment. However, fiduciaries also need to take into account costs when deciding whether and how to exercise their shareholder rights, including the voting of shares. Such costs include, but are not limited to, expenditures related to developing proxy resolutions, proxy voting services and the analysis of the likely net effect of a particular issue on the economic value of the plan’s investment. Fiduciaries must take all of these factors into account in determining whether the exercise of such rights (e.g., the voting of a proxy), independently or in conjunction with other shareholders, is expected to have an effect on the economic value of the plan’s investment that will outweigh the cost of exercising such rights. With respect to proxies appurtenant to shares of foreign corporations, a fiduciary, in deciding whether to purchase shares of a foreign corporation, should consider whether any additional difficulty and expense in voting such shares is reflected in their market price.

(2) Statements of Investment Policy

The maintenance by an employee benefit plan of a statement of investment policy designed to further the purposes of the plan and its funding policy is consistent with the fiduciary obligations set forth in ERISA section 404(a)(1)(A) and (B). Because the fiduciary act of managing plan assets that are shares of corporate stock includes the voting, where appropriate, of proxies appurtenant to those shares of stock, a statement of proxy voting policy would be an important part of any comprehensive statement of investment policy. For purposes of this document, the term “statement of investment policy” includes, but is not limited to, a statement of investment objectives, investment restrictions, a description of the voting of proxies, and a description of the powers and duties of the fiduciary to monitor such decisions.

2 See Advisory Opinion No. 2007–07A (December 21, 2007).

policy’ means a written statement that provides the fiduciaries who are responsible for plan investments with guidelines or general instructions concerning various types or categories of investment management decisions, which may include proxy voting decisions. A statement of investment policy is distinguished from directions as to the purchase or sale of specific investments at a specific time or as to voting specific plan proxies.

In plans where investment management responsibility is delegated to one or more investment managers appointed by the named fiduciary pursuant to ERISA Sec. 402(c)(3), inherent in the authority to appoint an investment manager, the named fiduciary responsible for appointment of investment managers has the authority to condition the appointment on acceptance of a statement of investment policy. Thus, such a named fiduciary may expressly require, as a condition of the investment management agreement, that an investment manager comply with the terms of a statement of investment policy that sets forth guidelines concerning investments and investment courses of action that the investment manager is authorized or is not authorized to make. Such investment policy may include a policy or guidelines on the voting of proxies on shares of stock for which the investment manager is responsible. Such guidelines must be consistent with the fiduciary obligations set forth in ERISA Sec. 404(a)(1)(A) and (B) and this Interpretive Bulletin, and may not subordinate the economic interests of the plan participants to unrelated objectives. In the absence of such an express requirement to comply with an investment policy, the authority to manage the plan assets placed under the control of the investment manager would lie exclusively with the investment manager. Although a trustee may be subject to the direction of a named fiduciary pursuant to ERISA Sec. 403(a)(1), an investment manager who has authority to make investment decisions, including proxy voting decisions, would never be relieved of its fiduciary responsibility if it followed the direction as to specific investment decisions from a named fiduciary or any other person.

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

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

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

An investment manager of a pooled investment vehicle that holds assets of more than one employee benefit plan may be subject to a proxy voting policy of one plan that conflicts with the proxy voting policy of another plan. If the investment manager determines that compliance with one of the conflicting voting policies would violate ERISA Sec. 404(a)(1), for example, by being imprudent or not solely in the economic interest of plan participants, the investment manager would be required to ignore the policy and vote in accordance with ERISA’s obligations. If, however, the investment manager reasonably concludes that application of each plan’s voting policy is consistent with ERISA’s obligations, such as when the policies reflect different but reasonable judgments or when the plans have different economic interests, ERISA Sec. 404(a)(1)(D) would generally require the manager, to the extent permitted by applicable law, to vote the proxies in proportion to each plan’s interest in the pooled investment vehicle.
investment manager may also require participating investors to accept the investment manager’s own investment policy statement, including any statement of proxy voting policy, before they are allowed to invest, which may help to avoid such potential conflicts. As with investment policies originating from named fiduciaries, a policy initiated by an investment manager and adopted by the participating plans would be regarded as an instrument governing the participating plans, and the investment manager’s compliance with such a policy would be governed by ERISA Sec. 404(a)(1)(D).

(3) Shareholder Activism

An investment policy that contemplates activities intended to monitor or influence the management of corporations in which the plan owns stock is consistent with a fiduciary’s obligations under ERISA where the responsible fiduciary concludes that there is a reasonable expectation that such monitoring or communication with management, by the plan alone or together with other shareholders, will enhance the economic value of the plan’s investment in the corporation, after taking into account the costs involved. Such a reasonable expectation may exist in various circumstances, for example, where plan investments in corporate stock are held as long-term investments or where a plan may not be able to easily dispose such an investment. Active monitoring and communication activities would generally concern such issues as the independence and expertise of candidates for the corporation’s board of directors and assuring that the board has sufficient information to carry out its responsibility to monitor management. Other issues may include such matters as consideration of the appropriateness of executive compensation, the corporation’s policy regarding mergers and acquisitions, the extent of debt financing and capitalization, the nature of long-term business plans, the corporation’s investment in training to develop its work force, other workplace practices and financial and non-financial measures of corporate performance that are reasonably likely to affect the economic value of the plan. Active monitoring and communication may be carried out through a variety of methods including by means of correspondence and meetings with corporate management as well as by exercising the legal rights of a shareholder. In creating an investment policy, a fiduciary shall consider only factors that relate to the economic interest of participants and their beneficiaries in plan assets, and shall not use an investment policy to promote myriad public policy preferences. 4

4 See Advisory Opinion No. 2008–05A (June 27, 2008) and letter from Department of Labor to Jonathan P. Hiatt, General Counsel, AFL-CIO (May 3, 2005).

Plan fiduciaries risk violating the exclusive purpose rule when they exercise their fiduciary authority in an attempt to further legislative, regulatory or public policy issues through the proxy process. In such cases, the Department would expect fiduciaries to be able to demonstrate in enforcement actions their compliance with the requirements of section 404(a)(1)(A) and (B). The mere fact that plans are shareholders in the corporations in which they invest does not itself provide a rationale for a fiduciary to spend plan assets to pursue, support, or oppose such proxy proposals. Because of the heightened potential for abuse in such cases, the fiduciaries must be prepared to articulate a clear basis for concluding that the proxy vote, the investment policy, or the activity intended to monitor or influence the management of the corporation is more likely than not to enhance the economic value of the plan’s investment before expending plan assets.

The use of pension plan assets by plan fiduciaries to further policy or political issues through proxy resolutions that have no connection to enhancing the economic value of the plan’s investment in a corporation would, in the view of the Department, violate the prudence and exclusive purpose requirements of section 404(a)(1)(A) and (B). For example, the likelihood that the adoption of a proxy resolution or proposal requiring corporate directors and officers to disclose their personal political contributions would enhance the economic value of a plan’s investment in the corporation appears sufficiently remote that the expenditure of plan assets to further such a resolution or proposal clearly raises compliance issues under section 404(a)(1)(A) and (B). 5


29 CFR Ch. XXV (7–1–15 Edition)
this title. Under that regulation, the assets of certain entities in which plans invest would include “plan assets” for purposes of the fiduciary responsibility provisions of the Act. Section 2510.3-101 applies only for purposes of identifying plan assets on or after the effective date of that section, however, and §2510.3-101 does not apply to plan investments in certain entities that qualify for the transitional relief provided for in paragraph (k) of that section. The principles discussed in paragraph (a) of this Interpretive Bulletin continue to be applicable for purposes of identifying assets of a plan for periods prior to the effective date of §2510.3-101 and for investments that are subject to the transitional rules in §2510.3-101(k). Paragraphs (b) and (c) of this Interpretive Bulletin, however, relate to matters outside the scope of §2510.3-101, and nothing in that section affects the continuing application of the principles discussed in those parts.

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

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

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

Thus, for example, if there is an arrangement under which a plan invests in, or retains its investment in, any investment by a plan in his own interest or for his own account.

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

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

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

Further, the Department of Labor emphasizes that it would consider a fiduciary who makes or retains an investment in a corporation or partnership for the purpose of avoiding the application of the fiduciary responsibility provisions of the Act to be in contravention of the provisions of section 401(a) of the Act.

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

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

On March 12, 1975, the Department of Labor issued an interpretive bulletin, ERISA IB 75-3, with regard to its interpretation of section 3(21)(B) of the Employee Retirement Income Security Act of 1974. That section provides
§ 2509.75–4

that an investment by an employee benefit plan in securities issued by an investment company registered under the Investment Company Act of 1940 shall not by itself cause the investment company, its investment adviser or principal underwriter to be deemed to be a fiduciary or party in interest except insofar as such investment company or its investment adviser or principal underwriter acts in connection with an employee benefit plan covering employees of the investment company, the investment adviser, or its principal underwriter.

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

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

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

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

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

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

Examples of such indemnification provisions are:

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

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

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

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

On June 25, 1975, the Department of Labor issued an interpretive bulletin, ERISA IB 75–5, containing questions and answers relating to certain aspects of the recently enacted
Employee Benefits Security Admin., Labor
§ 2509.75-5


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

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

INDEX

KEY TO QUESTION PREFIXES
D—Refers to Definitions
FR—Refers to Fiduciary Responsibility

<table>
<thead>
<tr>
<th>Section No.</th>
<th>Question No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3(21)</td>
<td>D-1</td>
</tr>
<tr>
<td>3(28)</td>
<td>FR-7</td>
</tr>
<tr>
<td>402(a)</td>
<td>FR-1, FR-2, FR-3</td>
</tr>
<tr>
<td>402(b)(1)</td>
<td>FR-4, FR-5</td>
</tr>
<tr>
<td>402(c)(3)</td>
<td>FR-6, FR-7</td>
</tr>
<tr>
<td>404(a)</td>
<td>FR-10</td>
</tr>
<tr>
<td>405(a)(3)</td>
<td>FR-10</td>
</tr>
<tr>
<td>405(b)(4)</td>
<td>FR-10</td>
</tr>
<tr>
<td>409(a)</td>
<td>FR-9</td>
</tr>
<tr>
<td>412(a)</td>
<td>FR-8, FR-9</td>
</tr>
</tbody>
</table>

D-1 Q: Is an attorney, accountant, actuary or consultant who renders legal, accounting, actuarial or consulting services to an employee benefit plan (other than an investment adviser to the plan) a fiduciary to the plan solely by virtue of the rendering of such services, absent a showing that such consultant (a) exercises discretionary authority or discretionary control respecting the management of the plan, (b) exercises authority or control respecting management or disposition of the plan’s assets, (c) renders investment advice for a fee, direct or indirect, with respect to the assets of the plan, or has any authority or responsibility to do so, or (d) has any discretionary authority or discretionary responsibility in the administration of the plan?

A: No. However, while attorneys, accountants, actuaries and consultants performing their usual professional functions will ordinarily not be considered fiduciaries, if the factual situation in a particular case falls within one of the categories described in clauses (a) through (d) of this question, such persons would be considered to be fiduciaries within the meaning of section 3(21) of the Act. The Internal Revenue Service notes that such persons would also be considered to be fiduciaries within the meaning of section 4975(e)(3) of the Internal Revenue Code of 1986.

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

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

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

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

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

A: Yes, it may. Section 402(a)(2) of the Act states that a “named fiduciary” is a fiduciary either named in the plan instrument or designated according to a procedure set forth in the plan instrument. A fiduciary is a “person” falling within the definition of fiduciary set forth in section 3(9) of the Act. A “person” may be a corporation under the definition of person contained in section 3(9) of the Act. While such designation satisfies the requirement of enabling employees...
§ 2509.75–5

29 CFR Ch. XXV (7–1–15 Edition)

and other interested persons to ascertain the person or persons responsible for operating the plan, a plan instrument which designates a corporation as “named fiduciary” should provide for designation by the corporation of specified individuals or other persons to carry out specified fiduciary responsibilities under the plan, in accordance with section 402(c)(3) of the Act.

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

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

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

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

FR–6 Q: May an investment adviser which is neither a bank nor an insurance company, and which is neither registered under the Investment Advisers Act of 1940 nor registered as an investment adviser in the State where it maintains its principal office and place of business, be appointed an investment manager under section 402(c)(3) of the Act?

A: No. The only persons who may be appointed an investment manager under section 402(c)(3) of the Act are persons who meet the requirements of section 3(38) of the Act—namely, banks (as defined in the Investment Advisers Act of 1940), insurance companies qualified under the laws of more than one state to manage, acquire and dispose of plan assets, persons registered as investment advisers under the Investment Advisers Act of 1940, or persons not registered under the Investment Advisers Act by reason of paragraph 1 of section 203(a)(1) of that Act who are registered as investment advisers in the State where they maintain their principal office and place of business in accordance with ERISA section 3(38) and who have met the filing requirements of 29 CFR 2510.3-38.

FR–7 Q: May an investment adviser that has a registration application pending for federal registration under the Investment Advisers Act of 1940, or pending with the appropriate state regulatory body under State investment adviser registration laws if relying on the provisions of 29 CFR 2510.3-38 to qualify as a state-registered investment manager, function as an investment manager under the Act prior to the effective date of their federal or state registration?

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

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

A: No. A person who renders investment advice, but who does not exercise or have the right to exercise discretionary authority with respect to plan assets, is not required to be bonded solely by reason of the provision of such investment advice. Such a person is not considered to be “handling” funds within the meaning of the temporary bonding regulation set forth in 29 CFR 2550.412-1, which incorporates by reference 29 CFR 461.7. For purposes of the temporary bonding regulation, only those fiduciaries who handle funds must be bonded. If, in addition to the rendering of investment advice, such person performs any additional function which constitutes the handling of plan funds under 29 CFR 461.7, the person would have to be bonded.

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

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

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

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

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

§ 2509.75–8

was prudent, and thus whether the advance was for reasonable expenses, is to be judged pursuant to section 404 of the Act (relating to fiduciary responsibilities).


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

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

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

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

INDEX

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

<table>
<thead>
<tr>
<th>Section No.</th>
<th>Question No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3(38)</td>
<td>D–2.</td>
</tr>
<tr>
<td>402(c)(1)</td>
<td>FR–16.</td>
</tr>
<tr>
<td>402(c)(2)</td>
<td>FR–12.</td>
</tr>
<tr>
<td>402(c)(3)</td>
<td>FR–15.</td>
</tr>
<tr>
<td>403(a)(2)</td>
<td>FR–15.</td>
</tr>
<tr>
<td>405(c)(1)</td>
<td>FR–12, FR–15.</td>
</tr>
<tr>
<td>405(c)(2)</td>
<td>FR–16.</td>
</tr>
<tr>
<td>412</td>
<td>D–2.</td>
</tr>
</tbody>
</table>

NOTE: Questions D–2, D–3, D–4, and D–5 relate to not only section 3(21)(A) of title I of the Act, but also section 4975(e)(3) of the Internal Revenue Code (section 2003 of the Act). The Internal Revenue Service has indicated its concurrence with the answers to these questions.

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

1. Application of rules determining eligibility for participation or benefits;
2. Calculation of services and compensation credits for benefits;
3. Preparation of employee communications material;
4. Maintenance of participants' service and employment records;
5. Preparation of reports required by government agencies;
6. Calculation of benefits;
7. Orientation of new participants and advising participants of their rights and options under the plan;
8. Collection of contributions and application of contributions as provided in the plan;
9. Preparation of reports concerning participants' benefits;
10. Processing of claims; and
11. Making recommendations to others for decisions with respect to plan administration?

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

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

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

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

A: Some offices or positions of an employee benefit plan by their very nature require persons who hold them to perform one or more of the functions described in section

426
3(21)(A) of the Act. For example, a plan administrator or a trustee of a plan must, be the very nature of his position, have “discretionary authority or discretionary responsibility in the administration” of the plan within the meaning of section 3(21)(A)(iii) of the Act. Persons who hold such positions will therefore be fiduciaries.

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

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

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

A: Members of the board of directors of an employer which maintains an employee benefit plan have “discretionary authority or discretionary responsibility in the administration” of the plan within the meaning of section 3(21)(A)(iii) of the Act. Persons who hold such positions will therefore be fiduciaries.

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

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

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

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

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

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

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

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

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

FR–13 Q: If the named fiduciaries of an employee benefit plan allocate their fiduciary
§ 2509.75–8

responsibilities among themselves in accordance with a procedure set forth in the plan for the allocation of responsibilities for operation and administration of the plan, to whom will a named fiduciary be relieved of liability for acts and omissions of other named fiduciaries in carrying out fiduciary responsibilities allocated to them?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) During the period of professional engagement to examine the financial statements being reported, at the date of the opinion, or during the period covered by the financial statements, the accountant or his or her firm or a member thereof had, or was committed to acquire, any direct financial interest or any material indirect financial interest in such plan, or the plan sponsor, as that term is defined in section 3(15)(B) of the Act.

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

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

However, an independent, qualified public accountant may permissibly engage in or have members of his or her firm engage in certain activities which will not have the effect of removing recognition of his or her independence. For example, (1) an accountant will not fail to be recognized as independent if at or during the period of his or her professional engagement with the employee benefit plan the accountant or his or her firm is retained or engaged on a professional basis by the plan sponsor, as that term is defined in section 3(15)(B) of the Act. However, to retain recognition of independence under such circumstances the accountant must not violate the prohibitions against recognition of independence established under paragraphs (1), (2) or (3) of this interpretive bulletin; (2) the rendering of services by an actuary associated with an accountant or accounting firm shall not impair the accountant’s or accounting firm’s independence. However, it should be noted that the rendering of services to a plan by an actuary and accountant employed by the same firm may constitute a prohibited transaction under section 406(a)(1)(C) of the Act. The rendering of such multiple services to a plan by a firm will be the subject of a later interpretive bulletin that will be issued by the Department of Labor.

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

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


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

On November 5, 1975, the Department of Labor (the “Department”) and the Internal Revenue Service (the “Service”) announced the publication of a compendium of authoritative rules (hereinafter referred to as the “ERISA Guidelines”) relating to ERISA requirements. See T.I.R. No. 1415 (November 5, 1975) issued by the Service. These rules were published in recognition of the need to provide an immediate and complete set of interim guidelines to facilitate (1) adoption of
new employee pension benefit plans (hereinafter referred to as "plans"), and (2) prompt amendment of existing plans, in conformance with the applicable requirements of the Employee Retirement Income Security Act of 1974 ("ERISA") pending the issuance of final regulations or other rules. These rules govern the application of (1) the qualification requirements of the Internal Revenue Code of 1954 (the "Code") added or amended by ERISA, and (2) the requirements of the provisions of parts 2 and 3 of title 1 of ERISA paralleling such qualification requirements (both such sets of requirements hereinafter referred to collectively as the "new qualification requirements").

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

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

The Service further announced that the ERISA Guidelines incorporate the procedures that will enable employers to obtain determination letters as to the qualification of pension, annuity, profit sharing, stock bonus and bond purchase plans which satisfy the requirements of sections 401(a), 403(a) and 406(a) of the Code, as amended by ERISA. The Service also pointed out that the ERISA Guidelines will enable sponsors of master and prototype plans (whether newly established or amended) to obtain determination letters as to the acceptability of the form of such plans, and, further, that employers who establish plans designed to meet the requirements of section 301(d) of the Tax Reduction Act of 1975 (relating to employee stock ownership plans) will be able to obtain determination letters as to the acceptability of such plans (whether or not such plans are intended to be qualified).

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

The Department announced that plans which comply with the Special Reliance Procedure will be considered by the Department as satisfying the requirements of the provisions of parts 2 and 3 of title 1 of ERISA which parallel the qualification requirements of the Code added or amended by ERISA to the same extent as such plans are considered by the Service as satisfying, in accordance with the terms of the Special Reliance Procedure, such qualification requirements.

The availability of the Special Reliance Procedure will substantially diminish the occasions for plans to avail themselves of the right to satisfy, for tax purposes, the qualification requirements of the Code (added or amended by ERISA) by retroactive amendments adopted during or after the close of a plan year, in accordance with section 401(b) of the Code and the temporary regulations thereunder. The Department pointed out that no explicit parallel provision to section 401(b) of the Code is contained in title 1 of

430
Employee Benefits Security Admin., Labor

§ 2509.75–10

ERISA. Nevertheless, to the extent retroactive amendments to a plan are made to satisfy the requirements of parts 2 and 3 of title I of ERISA which parallel the qualification requirements of the Code added or amended by ERISA, the Department noted that such plan will be in compliance with such requirements if such an amendment designed to satisfy such requirements (1) is adopted by the end of the plan year to which such requirements are applicable, and (2) is made effective for all purposes for such entire plan year.

The schedule of documents comprising the ERISA Guidelines follows.

<table>
<thead>
<tr>
<th>Publication date</th>
<th>Document</th>
<th>Subject</th>
<th>Code and ERISA sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 8</td>
<td>TIR 1334</td>
<td>Questions and answers relating to defined contribution plans subject to ERISA.</td>
<td>410, 411, et al.</td>
</tr>
<tr>
<td>Apr. 21</td>
<td>40 FR 17576</td>
<td>Notice of proposed rulemaking: Qualification (and other aspects) of HR–10 plans.</td>
<td>401(c), 401(d), 401(e), 46, 50A, 72, 404(e), 901, and 1379.</td>
</tr>
<tr>
<td>June 4</td>
<td>T.D. 7358</td>
<td>Temporary regulations: Notification of interested parties.</td>
<td>7476.</td>
</tr>
<tr>
<td>Sept. 8</td>
<td>40 FR 41654</td>
<td>Department of Labor—Minimum standards for hours of service, years of service, and breaks in service relating to participation, vesting, and accrual of benefits.</td>
<td>401(a)(3)(B), 411(a)(5)(C), and ERISA secs. 202, 203, and 204.</td>
</tr>
<tr>
<td>Sept. 17</td>
<td>TIR 1403</td>
<td>Questions and answers relating mainly to defined benefit plans subject to ERISA (addition to TIR 1334).</td>
<td>410, 411, et al.</td>
</tr>
<tr>
<td>Sept. 18</td>
<td>40 FR 43034</td>
<td>Notice of proposed rulemaking: Definitions of multi-employer plan and plan administrator.</td>
<td>414(f) and (g).</td>
</tr>
<tr>
<td>Sept. 29</td>
<td>T.D. 7377</td>
<td>Temporary regulations: Certain retroactive amendments of employee plans.</td>
<td>401(b).</td>
</tr>
<tr>
<td>Oct. 15</td>
<td>T.D. 7382</td>
<td>Temporary regulations: Requirement that benefits under a qualified plan are not decreased on account of certain social security increases.</td>
<td>401(a)(15).</td>
</tr>
<tr>
<td>Oct. 30</td>
<td>T.D. 7384</td>
<td>Notice of proposed rulemaking: Certain custodial accounts.</td>
<td>401(f).</td>
</tr>
<tr>
<td>Nov. 3</td>
<td>Rev. Rul. 75–480, 1975–44 IRB.</td>
<td>Guidelines for determining whether contributions or benefits under plan satisfy the limitations of sec. 415 of the code.</td>
<td>401(a)(12) and 414(1).</td>
</tr>
<tr>
<td>Nov. 4</td>
<td>TIR 1413</td>
<td>Questions and answers relating to employee stock ownership plans.</td>
<td>401(a)(4) and 411(d)(1).</td>
</tr>
<tr>
<td>Nov. 5</td>
<td>T.D. 7387</td>
<td>Temporary regulations on minimum vesting standards.</td>
<td>401, 4975, and sec. 301(d) of the Tax Reduction Act of 1975.</td>
</tr>
<tr>
<td></td>
<td>T.D. 7388</td>
<td>Controlled groups, businesses under common control, etc.</td>
<td>411.</td>
</tr>
<tr>
<td>(1)</td>
<td>TIR</td>
<td>Nonforfeiture of employee derived accrued benefit upon death.</td>
<td>411(a)(1).</td>
</tr>
<tr>
<td>Nov. 7</td>
<td>40 FR 52008</td>
<td>Department of Labor—additional requirements applicable to definition of multiemployer plan.</td>
<td>414(f) and ERISA sec. 3(37).</td>
</tr>
<tr>
<td>(1)</td>
<td>Assignment or alienation of plan benefits</td>
<td>401(a)(13).</td>
<td></td>
</tr>
</tbody>
</table>
§ 2509.78–1  Interpretive bulletin relating to payments by certain employee welfare benefit plans.

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

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

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

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

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

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

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

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

2 Section 403(c) and (d) provide certain exceptions to this requirement, not here relevant.
Employee Benefits Security Admin., Labor

§ 2509.94–3

Interpretive bulletin relating to in-kind contributions to employee benefit plans.

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

Under Reorganization Plan No. 4 of 1978 (33 FR 58656, Dec. 15, 1978), the authority of the Secretary of the Treasury to issue rulings under the prohibited transactions provisions of section 4975 of the Code has been transferred, with certain exceptions not here relevant, to the Secretary of Labor. Except with respect to the types of plans covered, the prohibited transaction provisions of section 406 of ERISA generally parallel the prohibited transaction of provisions of section 4975 of the Code.
§ 2509.95–1 29 CFR Ch. XXV (7–1–15 Edition)

Interpretive bulletin relating to the fiduciary standards under ERISA when selecting an annuity provider for a defined benefit pension plan.

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

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

[59 FR 66736, Dec. 28, 1994]
must evaluate a number of factors relating
In conducting such a search, a fiduciary
providers from which to purchase annuities.
for the purpose of identifying and selecting
at a minimum, that plan fiduciaries conduct
generation of prudence, described at section
must otherwise. In addition, the fiduciary obli-
that such a transfer occurs when the annuity
is issued by an insurance company licensed
do business in a State. 29 CFR 2510.3–
covered under the plan” for certain
purposes under title I of ERISA recognizes
that increased cost or other considerations
could never justify putting the benefits of
annuitized participants and beneficiaries at
risk by purchasing an unsafe annuity.
In contrast to the above, a fiduciary’s de-
cision to purchase more risky, lower-priced an-
nuities in order to ensure or maximize a re-
version of excess assets that will be paid
solely to the employer-sponsor in connection
with the termination of an over-funded pen-
sion plan would violate the fiduciary’s duties
under ERISA to act solely in the interest of
the plan participants and beneficiaries. In
"Selection of Annuity Providers. The sele-
ction of an annuity provider for purposes of
a pension benefit distribution, whether upon
separation or retirement of a participant or
upon the termination of a plan, is a fiduciary
decision governed by the provisions of part 4
of title I of ERISA. In discharging their obli-
gations under section 404(a)(1), 29 U.S.C.
1104(a)(1), to act solely in the interest of par-
ticipants and beneficiaries and for the exclu-
sive purpose of providing benefits to the par-
ticipants and beneficiaries as well as defray-
ing reasonable expenses of administering the
plan, fiduciaries choosing an annuity pro-
vider for the purpose of making a benefit dis-
tribution must take steps calculated to ob-
tain the safest annuity available, unless
under the circumstances it would be in the interests of participants and beneficiaries to
do otherwise. In addition, the fiduciary obli-
gation of prudence, described at section
404(a)(1)(B), 29 U.S.C. 1104(a)(1)(B), requires,
at a minimum, that plan fiduciaries conduct
an objective, thorough and analytical search
for the purpose of identifying and selecting
providers from which to purchase annuities.
In conducting such a search, a fiduciary
must evaluate a number of factors relating
to a potential annuity provider’s claims pay-
ing ability and creditworthiness. Reliance
solely on ratings provided by insurance rat-
ing services would not be sufficient to meet
this requirement. In this regard, a number of
factors a fiduciary should consider would in-
clude, among other things:

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

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

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

(4) The lines of business of the annuity pro-
vider and other indications of an insurer’s
exposure to liability;

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

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

(d) Costs and Other Considerations. The
Department recognizes that there are situa-
tions where it may be in the interest of the
participants and beneficiaries to purchase
other than the safest available annuity.
Such situations may occur where the safest
available annuity is only marginally safer,
but disproportionately more expensive than
competing annuities, and the participants
and beneficiaries are likely to bear a signifi-
cant portion of that increased cost. For ex-
ample, where the participants in a termi-
nating pension plan are likely to receive, in
the form of increased benefits, a substantial
share of the cost savings that would result
from choosing a competing annuity, it may
be in the interest of the participants to
choose the competing annuity. It may also
be in the interest of the participants and
beneficiaries to choose a competing annuity
of the annuity provider offering the safest
available annuity is unable to demonstrate
the ability to administer the payment of
benefits to the participants and benefi-
ciaries. The Department notes, however,
that increased cost or other considerations
would never justify putting the benefits of
annuitized participants and beneficiaries at
risk by purchasing an unsafe annuity.
In contrast to the above, a fiduciary’s deci-
sion to purchase more risky, lower-priced an-
nuities in order to ensure or maximize a re-
version of excess assets that will be paid
solely to the employer-sponsor in connection
with the termination of an over-funded pen-
sion plan would violate the fiduciary’s duties
under ERISA to act solely in the interest of
the plan participants and beneficiaries. In

Employee Benefits Security Admin., Labor § 2509.95–1

435

435

435

435

435
§ 2509.96–1

Interpretive bulletin relating to participant investment edu-
cation.

(a) Scope. This interpretive bulletin sets forth the Department of Labor's interpreta-
tion of section 3(21)(A)(ii) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), and 29 CFR 2510.3–21(c) as applied to the provision of investment-relat-
ed educational information to partici-
pants and beneficiaries in participant-di-
rected individual account pension plans (i.e., pension plans that permit participants and 
beneficiaries to direct the investment of as-
sets in their individual accounts, including 
plans that meet the requirements of the De-
partment's regulations at 29 CFR 2550.494c–1).

(b) General. Fiduciaries of an employee benefit plan are charged with carrying out their duties prudently and solely in the in-
terest of participants and beneficiaries of the plan, and are subject to personal liability to, among other things, make good any losses to the plan resulting from a breach of their fi-
duciary duties. ERISA sections 403, 404 and 409, 29 U.S.C. 1103, 1104, and 1109. Section 404(c) of ERISA provides a limited exception to these rules for a pension plan that permits a participant or beneficiary to exercise con-
trol over the assets in his or her individual account. The Department of Labor's regula-
tion, at 29 CFR 2550.494c–1, describes the

kinds of plans to which section 404(c) applies, the circumstances under which a participant or beneficiary will be considered to have ex-
ercised independent control over the assets in his or her account, and the consequences of a participant's or beneficiary's exercise of such control. 1

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

In response to these concerns, the Depart-
ment of Labor is clarifying herein the appli-
cability of ERISA section 3(21)(A)(ii) and 29 
CFR 2510.3–21(c) to the provision of invest-
ment-related educational information to 
participants and beneficiaries in participant
directed individual account plans. 2

1The section 404(c) regulation conditions relief from fiduciary liability on, among other things, the participant or beneficiary being provided or having the opportunity to obtain sufficient investment information re-
garding the investment alternatives avail-
able under the plan in order to make in-
formed investment decisions. Compliance 
with this condition, however, does not re-
quire that participants and beneficiaries be 
offered or provided either investment advice 
or investment education, e.g., regarding gen-
eral investment principles and strategies, to 
assist them in making investment decisions. 
29 CFR 2550.494c–1(c)(4).

2Issues relating to the circumstances under which information provided to partici-
pants and beneficiaries may affect a partici-
 pant’s or beneficiary’s ability to exercise independent control over the assets in his or 
her account for purposes of relief from fidu-
 ciary liability under ERISA section 404(c) 
are beyond the scope of this interpretive bul-
letin. Accordingly, no inferences should be 
drawn regarding such issues. See 29 CFR 
2550.494c–1(c)(2). It is the view of the Depart-
ment, however, that the provision of invest-
ment-related information and material to 
participants and beneficiaries in accordance

436
Employee Benefits Security Admin., Labor

§ 2509.96–1

does not address the “fee or other compensation, direct or indirect,” which is a necessary element of fiduciary status under ERISA section 3(21)(A)(i). The Department has expressed the view that, for purposes of section 3(21)(A)(i), such fees or other compensation need not come from the plan and should be deemed to include all fees or other compensation incident to the transaction in which the investment advice has been or will be rendered. See A.O. 83–60A (Nov. 21, 1983); Reich v. McManus, 883 F. Supp. 1144 (N.D. Ill. 1995).

The Department issued a regulation, at 29 CFR 2510.3–21(c), describing the circumstances under which a person will be considered to be rendering “investment advice” within the meaning of section 3(21)(A)(ii). Because section 3(21)(A)(ii) applies to advice with respect to “any moneys or other property” of a plan and 29 CFR 2510.3–21(c) is intended to clarify the application of that section, it is the view of the Department of Labor that the criteria set forth in the regulation apply to determine whether a person renders “investment advice” to a pension plan participant or beneficiary that the advice will serve as a primary basis for the participant’s or beneficiary’s investment decisions with respect to plan assets and that such person will render individualized advice based on the particular needs of the participant or beneficiary (2510.3–21(c)(1)(ii)(B)).

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

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

(1) Plan Information. (i) Information and materials that inform a participant or beneficiary about the benefits of plan participation, the benefits of increasing plan contributions, the impact of preretirement withdrawals on retirement income, the terms of the plan, or the operation of the plan; or (ii) information such as that described in 29 CFR 2550.404c-1(b)(2)(i) on investment alternatives under the plan (e.g., descriptions of investment objectives and philosophies, risk and return characteristics, historical return information, or related prospectuses).

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

4 Descriptions of investment alternatives under the plan may include information relating to the generic asset class (e.g., equities, bonds, or cash) of the investment alternatives. 29 CFR 2550.404c-1(b)(2)(i)(B)(ii).
The information and materials described above relate to the plan and plan participation, without reference to the appropriateness of any individual investment option for a particular participant or beneficiary under the plan. The information, therefore, does not contain either “advice” or “recommendations” within the meaning of 29 CFR 2510.3-21(c)(1)(i). Accordingly, the furnishing of such information would not constitute the rendering of “investment advice” for purposes of section 3(21)(A)(ii) of ERISA.

(2) General Financial and Investment Information. Information and materials that inform a participant or beneficiary about: (i) General financial and investment concepts, such as risk and return, diversification, dollar cost averaging, compounded return, and tax deferred investment; (ii) historic differences in rates of return between different asset classes (e.g., equities, bonds, or cash) based on standard market indices; (iii) effects of inflation; (iv) estimating future retirement income needs; (v) determining investment time horizons; and (vi) assessing risk tolerance.

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

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

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

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

§2509.96–1 29 CFR Ch. XXV (7–1–15 Edition) 438
The information provided through the use of the above-described materials enables participants and beneficiaries independently to design and assess multiple asset allocation models, but otherwise these materials do not differ from asset allocation models based on hypothetical assumptions. Such information would not constitute a “recommendation” within the meaning of 29 CFR 2510.3–2(1)(i) and, accordingly, would not constitute “investment advice” for purposes of section 404(c) plan, neither the designation of a person to provide education nor the designation of a fiduciary to serve as a fiduciary investment advisor. See ERISA section 405(a), 29 U.S.C. 1002 (21)(A)(i) and 404(a), 29 U.S.C. 1104(a). In addition, the designation of an investment advisor to serve as a fiduciary and necessary result of a participant’s or beneficiary’s exercise of independent control. 29 CFR 2550.404c–1(d). The Department also notes that a plan sponsor or fiduciary would have no fiduciary responsibility or liability with respect to the actions of a third party selected by a participant or beneficiary to provide education or investment advice where the plan sponsor or fiduciary neither selects nor endorses the educator or advisor, nor otherwise makes arrangements with the educator or advisor to provide such services.

The Department notes that the information and materials described in subparagraphs (1)–(4) above merely represent examples of the type of information and materials which may be furnished to participants and beneficiaries without such information and materials constituting “investment advice.” In this regard, the Department recognizes that there may be many other examples of information, materials, and educational services which, if furnished to participants and beneficiaries, would not constitute “investment advice.” Accordingly, no inferences should be drawn from subparagraphs (1)–(4), above, with respect to whether the furnishing of any information, materials or educational services not described therein may constitute “investment advice.” Determinations as to whether the provision of any information, materials or educational services not described herein constitutes the rendering of “investment advice” must be made by reference to the criteria set forth in 29 CFR 2510.3–2(c)(1).

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

[61 FR 29588, June 11, 1996]

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

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

(c) Employee communications. (1) It is the Department’s view that, so long as an employer maintains neutrality with respect to an IRA sponsor in its communications with

1 The views expressed in this Interpretive Bulletin with respect to payroll deduction programs of employers are also generally applicable to dues checkoff programs of employee organizations.
its employees, the employer will not be considered to “endorse” an IRA payroll deduction program for purposes of 29 CFR 2510.3-2(d). An employer may encourage its employees to participate in an IRA payroll deduction program and other educational materials that explain the advisability of retirement planning, including the advantages of contributing to an IRA, without thereby converting the program under which the employees’ wages are withheld for contribution into an IRA into an ERISA-covered plan:

However, the employer must make clear that its involvement in the program is limited to collecting the deducted amounts and remitting them promptly to the IRA sponsor and that it does not provide any additional benefit or promise any particular investment return on the employee’s savings.

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

(d) Employer Limitations on the number of IRA sponsors offered under the program. The Department recognizes that the cost of permitting employees to make IRA contributions through payroll deductions may be significantly affected by the number of IRA sponsors to which the employer must remit contributions. It is the view of the Department that an employer may limit the number of IRA sponsors to which the employer may make payroll deduction contributions without exceeding the limitations of 29 CFR 2510.3-2(d), provided that any limitations, or costs or assessments associated with an employee’s ability to transfer or roll over IRA contributions to another IRA sponsor is fully disclosed in advance of the employee’s decision to participate in the program. The employer may select one IRA sponsor as the designated recipient for payroll deduction contributions, or it may establish criteria by which to select IRA sponsors, e.g., standards relating to the sponsor’s provision of investment education, forms, availability to answer employees’ questions, etc., and may periodically review its selectees to determine whether to continue to designate them. However, an employer may be considered to be involved in the program beyond the limitations set forth in 29 CFR 2510.3-2(d) if the

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

3 For example, if the employer whose logo appeared on the promotional materials provided a statement along the lines of in the first sentence of footnote 5, the employer would not be considered to have endorsed the IRA product.
employer negotiates with an IRA sponsor and thereby obtains special terms and conditions for its employees that are not generally available to similar purchasers of the IRA. For purposes of this interpretive bulletin, the definition of ‘affiliate’ in ERISA section 407(d)(7) applies.

While the funding medium offered by an employer that is an IRA sponsor or an affiliate of an IRA sponsor might be considered an employer security when offered to its own employees, the fact that informational materials provided to employees identify the funding medium as having as one of its purposes investing in securities of the employer would not, in the Department’s view, involve the employer beyond the limits of 29 CFR 2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program would also be in excess of the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

employer's making payroll deduction available to its employees, or if the IRA sponsor agrees to extend credit to or for the benefit of the employer in return for the employer’s making payroll deduction available to the employees.

\[(g)\] Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

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

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

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Additional rules when employer is IRA sponsor or affiliate of IRA sponsor. Under certain circumstances, an employer that offers IRAs in the normal course of its business to the general public or that is an affiliate of an IRA sponsor may provide its employees with the opportunity to make contributions to IRAs sponsored by the employer or the affiliate through a payroll deduction program, without exceeding the limitations of §2510.3–2(d). If the IRA products offered to the employees for investment of the payroll deduction contributions are identical to IRA products the sponsor offers the general public in the ordinary course of its business, and any management fees, sales commissions, and the like charged by the IRA sponsor to employees participating in the payroll deduction program are the same as those charged by the sponsor to employees of non-affiliated employers that establish an IRA payroll deduction program, the Department has generally taken the position that this alone will not cause the employer to be sufficiently involved in the IRA program as an employer or to have received consideration of the type.

Employee Benefits Security Admin., Labor § 2509.99–1
prohibited under §2510.2(d)(iv) to warrant the program being considered outside the safe harbor of the regulation. Under such circumstances, the employer, in offering payroll deduction contribution opportunities to its employees, would appear to be acting generally as an IRA sponsor, rather than as the employer of the individuals who make the contributions.

[64 FR 33001, June 18, 1999]
PART 2510—DEFINITION OF TERMS USED IN SUBCHAPTERS C, D, E, F, G, AND L OF THIS CHAPTER

Sec.
2510.3–1 Employee welfare benefit plan.
2510.3–2 Employee pension benefit plan.
2510.3–3 Employee benefit plan.
2510.3–16 Definition of "plan administrator."
2510.3–21 Definition of "Fiduciary."
2510.3–37 Multiemployer plan.
2510.3–38 Filing requirements for State registered investment advisers to be investment managers.
2510.3–40 Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA.
2510.3–101 Definition of "plan assets"—plan investments.
2510.3–102 Definition of "plan assets"—participant contributions.


§ 2510.3–1 Employee welfare benefit plan.

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

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

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

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

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

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

(i) Overtime pay,
(ii) Shift premiums,
(iii) Holiday premiums,
(iv) Weekend premiums;

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

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

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

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

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

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

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

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

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

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

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

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

(f) Hiring halls. For purposes of title I of the Act and this chapter, the terms “employee welfare benefit plan” and
Employee Benefits Security Admin., Labor

§ 2510.3–2 Employee pension benefit plan.

(a) General. This section clarifies the limits of the defined terms “employee pension benefit plan” and “pension plan” for purposes of title I of the Act and this chapter by identifying certain specific plans, funds and programs which do not constitute employee pension benefit plans for those purposes.

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

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

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

(iii) All such payments to any employee are completed,
(A) In the case of an employee whose service is terminated in connection with a limited program of terminations, within the later of 24 months after the termination of the employee’s service, or 24 months after the employee reaches normal retirement age; and

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

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

(ii) “Limited program of terminations” means a program of terminations:
(A) Which, when begun, was scheduled to be completed upon a date certain or upon the occurrence of one or more specified events;
(B) Under which the number, percentage or class or classes of employees whose services are to be terminated is specified in advance; and
(C) Which is described in a written document which is available to the Secretary upon request, and which contains information sufficient to demonstrate that the conditions set forth in paragraphs (b)(2)(i)(A) and (B) of this section have been met.

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

(d) Individual Retirement Accounts. (1) For purposes of title I of the Act and this chapter, the terms “employee pension benefit plan” and “pension plan” shall not include an individual retirement account described in section 408(a) of the Code, an individual retirement annuity described in section 403(b) of the Internal Revenue Code of 1954 (hereinafter “the Code”) and an individual retirement bond described in section 409 of the Code, provided that—
(i) No contributions are made by the employer or employee association;
(ii) Participation is completely voluntary for employees or members;
(iii) The sole involvement of the employer or employee organization is without endorsement to permit the sponsor to publicize the program to employees or members, to collect contributions through payroll deductions or dues checkoffs and to remit them to the sponsor; and

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

(e) Gratuitous payments to pre-Act retirees. For purposes of title I of the Act and this chapter the terms “employee pension benefit plan” and “pension plan” shall not include voluntary, gratuitous payments by an employer to former employees who separated from the service of the employer if:
(1) Payments are made out of the general assets of the employer;
(2) Former employees separated from the service of the employer prior to September 2, 1974;
(3) Payments made to such employees commenced prior to September 2, 1974, and
(4) Each former employee receiving such payments is notified annually that the payments are gratuitous and do not constitute a pension plan.

(f) Tax sheltered annuities. For the purpose of title I of the Act and this chapter, a program for the purchase of an annuity contract or the establishment of a custodial account described in section 403(b) of the Internal Revenue Code of 1954 (the Code), pursuant to salary reduction agreements or agreements to forego an increase in salary, which meets the requirements of 26 CFR 1.403(b)–1(b)(3) shall not be “established or maintained by an employer” as that phrase is used in the definition of the terms “employee pension benefit plan” and “pension plan” if
(1) Participation is completely voluntary for employees;
(2) All rights under the annuity contract or custodial account are enforceable solely by the employee, by a beneficiary of such employee, or by any authorized representative of such employee or beneficiary;
(3) The sole involvement of the employer, other than pursuant to paragraph (f)(2) of this section, is limited to any of the following:
   (i) Permitting annuity contractors (which term shall include any agent or broker who offers annuity contracts or who makes available custodial accounts within the meaning of section 403(b)(7) of the Code) to publicize their products to employees,
   (ii) Requesting information concerning proposed funding media, products or annuity contractors;
   (iii) Summarizing or otherwise compiling the information provided with respect to the proposed funding media or products which are made available, or the annuity contractors whose services are provided, in order to facilitate review and analysis by the employees;
   (iv) Collecting annuity or custodial account considerations as required by salary reduction agreements or by agreements to forego salary increases, remitting such considerations to annuity contractors and maintaining records of such considerations;
   (v) Holding in the employer’s name one or more group annuity contracts covering its employees;
   (vi) Before February 7, 1978, to have limited the funding media or products available to employees, or the annuity contractors who could approach employees, to those which, in the judgment of the employer, afforded employees appropriate investment opportunities; or
   (vii) After February 6, 1978, limiting the funding media or products available to employees, or the annuity contractors who may approach employees, to a number and selection which is designed to afford employees a reasonable choice in light of all relevant circumstances. Relevant circumstances may include, but would not necessarily be limited to, the following types of factors:
(A) The number of employees affected,
(B) The number of contractors who have indicated interest in approaching employees,
(C) The variety of available products,
(D) The terms of the available arrangements,
(E) The administrative burdens and costs to the employer, and
(F) The possible interference with employee performance resulting from direct solicitation by contractors; and
(4) The employer receives no direct or indirect consideration or compensation in cash or otherwise other than reasonable compensation to cover expenses properly and actually incurred by such employer in the performance of the employer’s duties pursuant to the salary reduction agreements or agreements to forego salary increases described in this paragraph (f) of this section.

(g) Supplemental payment plans—(1) General rule. Generally, an arrangement by which a payment is made by an employer to supplement retirement income is a pension plan. Supplemental payments made on or after September 26, 1980, shall be treated as being made under a welfare plan rather than a pension plan for purposes of title I of the Act if all of the following conditions are met:
   (i) Payment is made for the purpose of supplementing the pension benefits of a participant or his or her beneficiary out of:
      (A) The general assets of the employer, or
      (B) A separate trust fund established and maintained solely for that purpose.
   (ii) The amount payable under the supplemental payment plan to a participant or his or her beneficiary with respect to a month does not exceed the payee’s supplemental payment factor (“SPF,” as defined in paragraph (g)(3)(i) of this section) for that month, provided however that unpaid monthly amounts may be cumulated and paid in subsequent months to the participant or his or her beneficiary.
   (iii) The payment is not made before the last day of the month with respect to which it is computed.
(2) Safe harbor for arrangements concerning pre-1977 retirees. (1) Notwithstanding paragraph (g)(1) of this section, effective January 1, 1975 an arrangement by which a payment is made by an employer to supplement the retirement income of a former employee who separated from the service of the employer prior to January 1, 1977 shall be deemed not to have been made under an employee benefit plan if all of the following conditions are met:

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

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

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

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

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

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

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

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

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

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

(I) If the plan provides an annuity option at the time of the distribution, the PBA shall be computed as if the distribution had been applied on that date to the purchase from an insurance company qualified to do business in a State of a commercially available level straight annuity for the life of the participant if the participant was unmarried at the time of the distribution or a joint and survivor annuity if the participant was married at the time of distribution.

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

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

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

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

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

(2) Where a plan participant has commenced to receive his or her pension benefits in the form of a straight-life annuity, or another form of an annuity that does not continue after the participant’s death in the form of a survivor annuity, no beneficiary of the participant will have a PBA.
(iii) The term “pension plan” means, for purposes of this paragraph (g), a pension plan as defined in section 3(2) of the Act, but not including a plan described in section 4(b), 201(2), or 301(a)(3) of the Act. The term also does not include an arrangement meeting all the conditions of paragraph (g)(1) or (g)(2) of this section or of an arrangement described in §2510.3–2(e). In the case of a controlled group of corporations within the meaning of section 407(d)(5) of the Act, all pension plans sponsored by members of the group shall be considered to be one pension plan.

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

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

\[
\frac{a - b}{b}
\]

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

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

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

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

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

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

SPF for July 1980:

\[
SPF = \frac{a - b}{b} \times PBA = \frac{247.8 - 247.8}{247.8} \times 600 = 0.00
\]

SPF for August 1980:

\[
SPF = \frac{249.4 - 247.8}{247.8} \times 600 = 3.87
\]

SPF for September 1980:

\[
SPF = \frac{251.7 - 247.8}{247.8} \times 600 = 9.44
\]

Total = $0.00 + 3.87 + 9.44 = $13.31

No supplemental payment may be made to R as a welfare plan payment with respect to July 1980, the month of retirement. The $3.87 that may be paid with respect to August 1980 may be paid at any time after August 31,
§ 2510.3–3

Employer benefit plan.

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

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

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

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

SPF for July 1980:

\[ SPF = \frac{247.8 - 247.8}{247.8} \times 500 = 0.00 \]

SPF for August 1980:

\[ SPF = \frac{249.4 - 247.8}{247.8} \times 500 = 3.23 \]

SPF for September 1980:

\[ SPF = \frac{251.7 - 247.8}{247.8} \times 500 = 7.87 \]

Total = $0.00 + 3.23 + 7.87 = $11.10

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

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

SPF for July 1980 = $0.00

SPF for August 1980 = $3.23

SPF for September 1980 = $7.87

SPF for October 1980:

\[ SPF = \frac{253.9 - 247.8}{247.8} \times 300 = 12.31 \]

(Note that T's "b" is equal to Q's "b".)

SPF for November 1980:

\[ SPF = \frac{256.2 - 247.8}{247.8} \times 300 = 10.17 \]

Total that may be paid to T

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

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

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

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

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

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

(d) **Participant covered under the plan.**

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

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

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

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

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

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

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

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

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

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

(2) The amount of benefits to which the individual is entitled, whichever results in earlier participation...

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

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

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

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

(A) The entire benefit rights of the individual—

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

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

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

(3) In the case of an employee pension benefit plan, an individual who, under the terms of the plan, has incurred a one-year break in service after having become a participant covered...
under the plan, and who has acquired no vested right to a benefit before such break in service is not a participant covered under the plan until the individual has completed a year of service after returning to employment covered by the plan.

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

[40 FR 34530, Aug. 15, 1975]

§ 2510.3–16 Definition of “plan administrator.”

(a) In general. The term “plan administrator” or “administrator” means the person specifically so designated by the terms of the instrument under which the plan is operated. If an administrator is not so designated, the plan administrator is the plan sponsor, as defined in section 3(16)(B) of ERISA.

(b) In the case of a self-insured group health plan established or maintained by an eligible organization, as defined in §2590.715–2713A(a) of this chapter, if the eligible organization provides a copy of the self-certification of its objection to administering or funding any contraceptive benefits in accordance with §2590.715–2713A(b)(1)(ii) of this chapter to a third party administrator, the self-certification shall be an instrument under which the plan is operated, and shall supersede any earlier designation. If, instead, the eligible organization notifies the Secretary of Health and Human Services of its objection to administering or funding any contraceptive benefits in accordance with §2590.715–2713A(b)(1)(ii) of this chapter, the Department of Labor, working with the Department of Health and Human Services, shall separately provide notification to each third party administrator that such third party administrator shall be the plan administrator under section 3(16) of ERISA for any contraceptive services required to be covered under §2590.715–2713A(a)(1)(iv) of this chapter to which the eligible organization objects on religious grounds, with respect to benefits for contraceptive services that the third party administrator would otherwise manage. Such notification from the Department of Labor shall be an instrument under which the plan is operated and shall supersede any earlier designation.

(c) A third party administrator that becomes a plan administrator pursuant to this section shall be responsible for—

(1) Complying with section 2713 of the Public Health Service Act (42 U.S.C. 300gg–15) (as incorporated into section 715 of ERISA) and §2590.715–2713 of this chapter with respect to coverage of contraceptive services. To the extent the plan contracts with different third party administrators for different classifications of benefits (such as prescription drug benefits versus inpatient and outpatient benefits), each third party administrator is responsible for providing contraceptive coverage that complies with section 2713 of the Public Health Service Act (as incorporated into section 715 of ERISA) and §2590.715–2713 of this chapter with respect to the classification or classifications of benefits subject to its contract.

(2) Establishing and operating a procedure for determining such claims for contraceptive services in accordance with §2560.503–1 of this chapter.

(3) Complying with disclosure and other requirements applicable to group health plans under Title I of ERISA with respect to such benefits.


§ 2510.3–21 Definition of “Fiduciary.”

(a)–(b) [Reserved]

(c) Investment advice. (1) A person shall be deemed to be rendering “investment advice” to an employee benefit plan, within the meaning of section 3(21)(A)(ii) of the Employee Retirement Income Security Act of 1974, if he renders advice to or on behalf of such plan with respect to the selection or purchase of any investment contract, or the execution of any agreement relating to such an investment contract, if the person rendering such advice—

(i) has decision-making authority over the plan's investments; or

(ii) provides investment advice to the plan or any person who renders investment advice to the plan; and

(iii) such person is not a person described in paragraph (b)(2) of this section.

Such advice is not investment advice if—

(i) the advice is part of the financial services of a registered investment company, mutual fund, or bank trust;

(ii) the advice is solely a recommendation that an investment be made in a portfolio of securities, investment contracts, or other investment vehicles; or

(iii) the person rendering the advice is acting as an agent or fiduciary of an entity that has decision-making authority over the plan's investments, and such person is not a person described in paragraph (b)(2) of this section.

(2) In the case of a group health plan, a person is not a person described in paragraph (c)(1) of this section with respect to any liability of the plan or any person who renders investment advice to the plan, if—

(i) the person has no direct responsibility for selecting or monitoring the investments of the plan; or

(ii) the person is not a person described in paragraph (b)(2) of this section.

Income Security Act of 1974 (the Act) and this paragraph, only if:

(i) Such person renders advice to the plan as to the value of securities or other property, or makes 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 strategy, overall portfolio composition, or diversification of plan investments.

(2) A person who is a fiduciary with respect to a plan by reason of rendering investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or having any authority or responsibility to do so, shall not be deemed to be a fiduciary, within the meaning of section 3(21)(A) of the Act, with respect to an employee benefit plan solely because such person executes transactions for the purchase or sale of securities on behalf of such plan in the ordinary course of its business as a broker, dealer, or bank, pursuant to instructions of a fiduciary with respect to such plan, if:

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

(ii) The instructions specify (A) the security to be purchased or sold, (B) a price range within which such security is to be purchased or sold, or, if such security is purchased or sold for a fixed price 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, the instructions 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 406(a) of the Act concerning liability for fiduciary breaches by other fiduciaries with respect to any assets of the plan; or

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

(d) Execution of securities transactions.

(1) A person who is a broker or dealer registered under the Securities Exchange Act of 1934, a reporting dealer who makes primary markets in securities of the United States Government or of an agency of the United States Government and reports daily to the Federal Reserve Bank of New York its positions with respect to such securities and borrowings thereon, or a bank supervised by the United States or a State, shall not be deemed to be a fiduciary 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 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, or the value of such security in dollar amount which may be purchased or sold, at the price referred to in paragraph (d)(1)(ii)(B) of this section.
(2) A person who is a broker-dealer, reporting dealer, or bank which is a fiduciary with respect to an employee benefit plan solely by reason of the possession or exercise of discretionary authority or discretionary control in the management of the plan or the management or disposition of plan assets in connection with the execution of a transaction or transactions for the purchase or sale of securities on behalf of such plan which fails to comply with the provisions of paragraph (d)(1) of this section, shall not be deemed to be a fiduciary regarding any assets of the plan with respect to which such broker-dealer, reporting dealer or bank does not have any discretionary authority, discretionary control or discretionary responsibility, does not exercise any authority or control, does not render investment advice (as defined in paragraph (c)(1) of this section) for a fee or other compensation, and does not have any authority or responsibility to render such investment advice, provided that nothing in this paragraph shall be deemed to:

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

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

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

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

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

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

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

[40 FR 50843, Oct. 31, 1975]

§ 2510.3–37 Multiemployer plan.

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

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

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

(i)(A) The plan was reduced to writing and adopted by the participating employers and the employee organization (including, in the case of a corporate employer, formal approval by an employer’s board of directors or shareholders, if required), even though no amounts had been contributed under the plan, and

(B) The plan has not been terminated; or

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

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

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

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

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

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

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

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

[40 FR 52008, Nov. 7, 1975]

§ 2510.3–38 Filing requirements for State registered investment advisers to be investment managers.

(a) General. Section 3(38) of the Act sets forth the criteria for a fiduciary to be an investment manager for purposes of section 405 of the Act. Subparagraph (B)(ii) of section 3(38) of the Act provides that, in the case of a fiduciary who is not registered under the Investment Advisers Act of 1940 by reason of paragraph (1) of section 203A(a) of such Act, the fiduciary must be registered as an investment adviser under the laws of the State in which it maintains its principal office and place of business, and, at the time the fiduciary files registration forms with such State to maintain the fiduciary’s registration under the laws of such State, also files a copy of such forms with the Secretary of Labor. The purpose of this section is to set forth the exclusive means for investment advisers to satisfy the filing obligation with the Secretary described in subparagraph (B)(ii) of section 3(38) of the Act.

(b) Filing requirement. To satisfy the filing requirement with the Secretary in section 3(38)(B)(ii) of the Act, a fiduciary must be registered as an investment adviser with the State in which it maintains its principal office and place of business and file through the Investment Adviser Registration Depository (IARD), in accordance with applicable IARD requirements, the information required to be registered and maintain the fiduciary’s registration as an investment adviser in such State. Submitting to the Secretary investment adviser registration forms filed with a State does not constitute compliance with the filing requirement in section 3(38)(B)(ii) of the Act.

(c) Definitions. For purposes of this section, the term “Investment Adviser Registration Depository” or “IARD” means the centralized electronic depository described in 17 CFR 275.203-1.

(d) Cross reference. Information for investment advisers on how to file through the IARD is available on the Securities and Exchange Commission website at www.sec.gov/iard.

[69 FR 52125, Aug. 24, 2004]

§ 2510.3–40 Plans Established or Maintained Under or Pursuant to Collective Bargaining Agreements Under Section 3(40)(A) of ERISA.

(a) Scope and purpose. Section 3(40)(A) of the Employee Retirement Income Security Act of 1974 (ERISA) provides that the term “multiple employer welfare arrangement” (MEWA) does not include an employee welfare benefit plan that is established or maintained under or pursuant to collective bargaining agreements. This section sets forth criteria that represent a finding by the Secretary whether an arrangement is an employee welfare benefit plan established or maintained under or pursuant to one or more collective bargaining agreements. A plan is established or maintained under or pursuant to collective
bargaining if it meets the criteria in this section. However, even if an entity meets the criteria in this section, it will not be an employee welfare benefit plan established or maintained under or pursuant to a collective bargaining agreement if it comes within the exclusions in the section. Nothing in or pursuant to this section shall constitute a finding for any purpose other than the exception for plans established or maintained under or pursuant to one or more collective bargaining agreements under section 3(40) of ERISA. In a particular case where there is an attempt to assert state jurisdiction or the application of state law with respect to a plan or other arrangement that allegedly is covered under Title I of ERISA, the Secretary has set forth a procedure for obtaining individualized findings at 29 CFR part 2570, subpart H.

(b) General criteria. The Secretary finds, for purposes of section 3(40) of ERISA, that an employee welfare benefit plan is “established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements” for any plan year in which the plan meets the criteria set forth in paragraphs (b)(1), (2), (3), and (4) of this section, and is not excluded under paragraph (c) of this section.

(1) The entity is an employee welfare benefit plan within the meaning of section 3(1) of ERISA.

(2) At least 85% of the participants in the plan are:
   (i) Individuals employed under one or more agreements meeting the criteria of paragraph (b)(3) of this section, under which contributions are made to the plan, or pursuant to which coverage under the plan is provided;
   (ii) Retirees who either participated in the plan at least five of the last 10 years preceding their retirement, or
   (A) Are receiving benefits as participants under a multiemployer pension benefit plan that is maintained under the same agreements referred to in paragraph (b)(3) of this section, and
   (B) Have at least five years of service or the equivalent under that multiemployer pension benefit plan;
   (iii) Participants on extended coverage under the plan pursuant to the requirements of a statute or court or administrative agency decision, including but not limited to the continuation coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, sections 601–609, 29 U.S.C. 1169, the Family and Medical Leave Act, 29 U.S.C. 2601 et seq., the Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. 4301 et seq., or the National Labor Relations Act, 29 U.S.C. 158(a)(5);
   (iv) Participants who were active participants and whose coverage is otherwise extended under the terms of the plan, including but not limited to extension by reason of self-payment, hour bank, long or short-term disability, furlough, or temporary unemployment, provided that the charge to the individual for such extended coverage is no more than the applicable premium under section 604 of the Act;
   (v) Participants whose coverage under the plan is maintained pursuant to a reciprocal agreement with one or more other employee welfare benefit plans that are established or maintained under or pursuant to one or more collective bargaining agreements and that are multiemployer plans;
   (vi) Individuals employed by:
   (A) An employee organization that sponsors, jointly sponsors, or is represented on the association, committee, joint board of trustees, or other similar group of representatives of the parties who sponsor the plan;
   (B) The plan or associated trust fund;
   (C) Other employee benefit plans or trust funds to which contributions are made pursuant to the same agreement described in paragraph (b)(3) of this section; or
   (D) An employer association that is the authorized employer representative that actually engaged in the collective bargaining that led to the agreement that references the plan as described in paragraph (b)(3) of this section;
   (vii) Individuals who were employed under an agreement described in paragraph (b)(3) of this section, provided that they are employed by one or more employers that are parties to an agreement described in paragraph (b)(3) and are covered under the plan on terms that are generally no more favorable
(viii) Individuals (other than individuals described in paragraph (b)(2)(i) of this section) who are employed by employers that are bound by the terms of an agreement described in paragraph (b)(3) of this section and that employ personnel covered by such agreement, and who are covered under the plan on terms that are generally no more favorable than those that apply to such covered personnel. For this purpose, such individuals in excess of 10% of the total population of participants in the plan are disregarded;

(ix) Individuals who are, or were for a period of at least three years, employed under one or more agreements between or among one or more “carriers” (including “carriers by air”) and one or more “representatives” of employees for collective bargaining purposes and as defined by the Railway Labor Act, 45 U.S.C. 151 et seq., providing for such individuals’ current or subsequent participation in the plan, or providing for contributions to be made to the plan by such carriers; or

(x) Individuals who are licensed marine pilots operating in United States ports as a state-regulated enterprise and are covered under an employee welfare benefit plan that meets the definition of a qualified merchant marine plan, as defined in section 415(b)(2)(F) of the Internal Revenue Code (26 U.S.C.).

(3) The plan is incorporated or referenced in a written agreement between one or more employers and one or more employee organizations, which agreement, itself or together with other agreements among the same parties:

(i) Is the product of a bona fide collective bargaining relationship between the employers and the employee organization(s);

(ii) Identifies employers and employee organization(s) that are parties to and bound by the agreement;

(iii) Identifies the personnel, job classifications, and/or work jurisdiction covered by the agreement;

(iv) Provides for terms and conditions of employment in addition to coverage under, or contributions to, the plan; and

(v) Is not unilaterally terminable or automatically terminated solely for non-payment of benefits under, or contributions to, the plan.

(4) For purposes of paragraph (b)(3)(i) of this section, the following factors, among others, are to be considered in determining the existence of a bona fide collective bargaining relationship. In any proceeding initiated under 29 CFR part 2570 subpart H, the existence of a bona fide collective bargaining relationship under paragraph (b)(3)(i) shall be presumed where at least four of the factors set out in paragraphs (b)(4)(i) through (viii) of this section are established. In such a proceeding, the Secretary may also consider whether other objective or subjective indicia of actual collective bargaining and representation are present as set out in paragraph (b)(4)(ix) of this section.

(i) The agreement referred to in paragraph (b)(3) of this section provides for contributions to a labor-management trust fund structured according to section 302(c)(5), (6), (7), (8), or (9) of the Taft-Hartley Act, 29 U.S.C. 186(c)(5), (6), (7), (8) or (9), or to a plan lawfully negotiated under the Railway Labor Act;

(ii) The agreement referred to in paragraph (b)(3) of this section requires contributions by substantially all of the participating employers to a multi-employer pension plan that is structured in accordance with section 401 of the Internal Revenue Code (26 U.S.C.) and is either structured in accordance with section 302(c)(5) of the Taft-Hartley Act, 29 U.S.C. 186(c)(5), or is lawfully negotiated under the Railway Labor Act, and substantially all of the active participants covered by the employee welfare benefit plan are also eligible to become participants in that pension plan;

(iii) The predominant employee organization that is a party to the agreement referred to in paragraph (b)(3) of this section has maintained a series of agreements incorporating or referencing the plan since before January 1, 1983;
(iv) The predominant employee organization that is a party to the agreement referred to in paragraph (b)(3) of this section has been a national or international union, or a federation of national and international unions, or has been affiliated with such a union or federation, since before January 1, 1983;

(v) A court, government agency, or other third-party adjudicatory tribunal has determined, in a contested or adversary proceeding, or in a government-supervised election, that the predominant employee organization that is a party to the agreement described in paragraph (b)(3) of this section is the lawfully recognized or designated collective bargaining representative with respect to one or more bargaining units of personnel covered by such agreement;

(vi) Employers who are parties to the agreement described in paragraph (b)(3) of this section pay at least 75% of the premiums or contributions required for the coverage of active participants under the plan or, in the case of a retiree-only plan, the employers pay at least 75% of the premiums or contributions required for the coverage of the retirees. For this purpose, coverage under the plan for dental or vision care, coverage for excepted benefits under 29 CFR 2590.732(b), and amounts paid by participants and beneficiaries as co-payments or deductibles in accordance with the terms of the plan are disregarded;

(vii) The predominant employee organization that is a party to the agreement described in paragraph (b)(3) of this section provides, sponsors, or jointly sponsors a hiring hall(s) and/or a state-certified apprenticeship program(s) that provides services that are available to substantially all active participants covered by the plan;

(viii) The agreement described in paragraph (b)(3) of this section has been determined to be a bona fide collective bargaining agreement for purposes of establishing the prevailing practices with respect to wages and supplements in a locality, pursuant to a prevailing wage statute of any state or the District of Columbia.

(ix) There are other objective or subjective indicia of actual collective bargaining and representation, such as that arm’s-length negotiations occurred between the parties to the agreement described in paragraph (b)(3) of this section; that the predominant employee organization that is party to such agreement actively represents employees covered by such agreement with respect to grievances, disputes, or other matters involving employment terms and conditions other than coverage under, or contributions to, the employee welfare benefit plan; that there is a geographic, occupational, trade, organizing, or other rationale for the employers and bargaining units covered by such agreement; that there is a connection between such agreement and the participation, if any, of self-employed individuals in the employee welfare benefit plan established or maintained under or pursuant to such agreement.

(c) Exclusions. An employee welfare benefit plan shall not be deemed to be “established or maintained under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements” for any plan year in which:

(1) The plan is self-funded or partially self-funded and is marketed to employers or sole proprietors

(i) By one or more insurance producers as defined in paragraph (d) of this section;

(ii) By an individual who is disqualified from, or ineligible for, or has failed to obtain, a license to serve as an insurance producer to the extent that the individual engages in an activity for which such license is required; or

(iii) By individuals (other than individuals described in paragraphs (c)(1)(i) and (ii) of this section) who are paid on a commission-type basis to market the plan.

(iv) For the purposes of this paragraph (c)(1):

(A) “Marketing” does not include administering the plan, consulting with plan sponsors, counseling on benefit design or coverage, or explaining the terms of coverage available under the plan to employees or union members;

(B) “Marketing” does include the marketing of union membership that carries with it plan participation by virtue of such membership, except for
membership in unions representing insurance producers themselves;

(2) The agreement under which the plan is established or maintained is a scheme, plan, stratagem, or artifice of evasion, a principal intent of which is to evade compliance with state law and regulations applicable to insurance; or

(3) There is fraud, forgery, or willful misrepresentation as to the factors relied on to demonstrate that the plan satisfies the criteria set forth in paragraph (b) of this section.

(d) Definitions. (1) Active participant means a participant who is not retired and who is not on extended coverage under paragraphs (b)(2)(iii) or (b)(2)(iv) of this section.

(2) Agreement means the contract embodying the terms and conditions mutually agreed upon between or among the parties to such agreement. Where the singular is used in this section, the plural is automatically included.

(3) Individual employed means any natural person who furnishes services to another person or entity in the capacity of an employee under common law, without regard to any specialized definitions or interpretations of the terms “employee,” “employer,” or “employed” under federal or state statutes other than ERISA.

(4) Insurance producer means an agent, broker, consultant, or producer who is an individual, entity, or sole proprietor that is licensed under the laws of the state to sell, solicit, or negotiate insurance.

(5) Predominant employee organization means, where more than one employee organization is a party to an agreement, either the organization representing the plurality of individuals employed under such agreement, or organizations that in combination represent the majority of such individuals.

(e) Examples. The operation of the provisions of this section may be illustrated by the following examples.

Example 1. Plan A has 500 participants, in the following 4 categories of participants under paragraph (b)(2) of this section:

<table>
<thead>
<tr>
<th>Categories of participants</th>
<th>Total number</th>
<th>Nexus group</th>
<th>Non-nexus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individuals working under CBAs ...</td>
<td>335 (67%)</td>
<td>335 (67%)</td>
<td>0</td>
</tr>
<tr>
<td>2. Retirees ...</td>
<td>50 (10%)</td>
<td>50 (10%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Example 2. (i) International Union MG and its Local Unions have represented people working primarily in a particular industry for over 60 years. Since 1950, most of their collective bargaining agreements have called for those workers to be covered by the National MG Health and Welfare Plan. During that time, the number of union-represented workers in the industry, and the number of active participants in the National MG Health and Welfare Plan, first grew and then declined. New Locals were formed and later were shut down. Despite these fluctuations, the National MG Health and Welfare Plan meets the factors described in paragraphs (b)(4)(iii) and (iv) of this section, as the plan has been in existence pursuant to collective bargaining agreements to which the International Union and its affiliates have been parties since before January 1, 1983.

(ii) Assume the same facts, except that on January 1, 1990, International Union MG merged with International Union RE to form
Example 4. (i) Pursuant to a collective bargaining agreement between various employers and Local 2000, the employers contribute $2 per hour to the Fund for every hour that a covered employee works under the agreement. The covered employees are automatically entitled to health and disability coverage from the Fund for every calendar quarter if they have 300 hours of additional covered service in the preceding quarter. The employees do not need to make any additional contributions for their own coverage, but must pay $250 per month if they want health coverage for their dependent spouse and children. Because the employer payments cover 100% of the required contributions for the employees’ own coverage, the Local 2000 Employers Health and Welfare Fund meets the “75% employer payment” factor under paragraph (b)(4)(vi) of this section.

(ii) Assume, however, that the negotiated employer contribution rate was $1 per hour, and the employees could only obtain health coverage for themselves if they also elected to contribute $1 per hour, paid on a pre-tax basis through salary reduction. The Fund would not meet the 75% employer payment factor, even though the employees’ contributions are treated as employer contributions for tax purposes. Under ERISA, and therefore under this section, elective salary reduction contributions are treated as employee contributions. The outcome would be the same if a uniform employee contribution rate applied to all employees, whether they had individual or family coverage, so that the $1 per hour employee contribution qualified an employee for his or her own coverage and, if he or she had dependents, dependent coverage as well.

Example 5. Arthur is a licensed insurance broker, one of whose clients is Multiemployer Fund M, a partially self-funded plan. Arthur takes bids from insurance companies on behalf of Fund M for the insured portion of its coverage, helps the trustees to evaluate the bids, and places the Fund’s health insurance coverage with the carrier that is selected. Arthur also assists the trustees of Fund M in preparing material to explain the plan and its benefits to the participants, as well as in monitoring the insurance company’s performance under the contract. At the Trustees’ request, Arthur meets with a group of employers with which the union is negotiating for their employees’ coverage under Fund M, and he explains the cost structure and benefits that Fund M provides. Arthur is not engaged in marketing within the meaning of paragraph (c)(1) of this section, so the fact that he provides these administrative services and sells insurance to the Fund itself does not affect the plan’s status as a plan established or maintained under or pursuant to a collective bargaining agreement. This is the case whether or how he is compensated.

Example 6. Assume the same facts as Example 5, except that Arthur has a group of clients who are unrelated to the employers bound by the collective bargaining agreement, whose employees would not be “nexus group” members, and whose insurance carrier has withdrawn from the market in their...
locality. He persuades the client group to retain him to find them other coverage. The client group has no relationship with the labor union that represents the participants in Fund M. However, Arthur offers them coverage under Fund M and persuades the Fund’s Trustees to allow the client group to join Fund M in order to broaden Fund M’s coverage. Mr. Thompson’s activities in obtaining coverage for the unrelated group under Fund M constitutes marketing through an insurance producer; Fund M is a MEWA under paragraph (c)(1) of this section.

Example 7. Union A represents thousands of construction workers in a three-state geographic region. For many years, Union A has maintained a standard written collective bargaining agreement with several hundred large and small building contractors, covering wages, hours, and other terms and conditions of employment for all work performed in Union A’s geographic territory. The terms of those agreements are negotiated every three years between Union A and a multiemployer Association, which signs on behalf of those employers who have delegated their bargaining authority to the Association. Hundreds of other employers—including both local and traveling contractors—have chosen to become bound to the terms of Union A’s standard area agreement for various periods of time and in various ways, such as by signing short-form binders or “me too” agreements, executing a single job or project labor agreement, or entering into a subcontracting arrangement with a signatory employer. All of these employ individuals represented by Union A and contribu to Plan A, a self-insured multiemployer health and welfare plan established and maintained under Union A’s standard area agreement. During the past year, the trustees of Plan A have brought lawsuits against several signatory employers seeking contributions allegedly owed, but not paid to the trust. In defending that litigation, a number of employers have sworn that they never intended to operate as union contractors, that their employees want nothing to do with Union A, that Union A procured their assent to the collective bargaining agreement solely by threats and fraudulent misrepresentations, and that Union A has failed to file certain reports required by the Labor Management Reporting and Disclosure Act. In at least one instance, a petition for a decertification election has been filed with the National Labor Relations Board. In this example, Plan A meets the criteria for a regulatory finding under this section that it is a multiemployer plan established and maintained under or pursuant to one or more collective bargaining agreements, assuming that its participant population satisfies the 85% test of paragraph (b)(2) of this section and that none of the disqualifying factors in paragraph (c) of this section is present. Plan A’s status for the purpose of this section is not affected by the fact that some of the employers who deal with Union A have challenged Union A’s conduct, or have disputed labor statutes and labor statutes other than ERISA section 3(40) the validity and enforceability of their putative contract with Union A, regardless of the outcome of those disputes.

Example 8. Assume the same facts as Example 7. Plan A’s benefits consultant recently entered into an arrangement with the Medical Consortium, a newly formed organization of health care providers, which allows the Plan to offer a broader range of health services to Plan A’s participants while achieving cost savings to the Plan and to participants. Union A, Plan A, and Plan A’s consultant each have added a page to their Web sites publicizing the new arrangement with the Medical Consortium. Concurrently, Medical Consortium’s Web site prominently publicizes its recent affiliation with Plan A and the innovative services it makes available to the Plan’s participants. Union A has mailed out informational packets to its members describing the benefit enhancements and encouraging election of family coverage. Union A has also begun distributing similar material to workers on hundreds of non-union construction job sites within its geographic territory. In this example, Plan A remains a plan established and maintained under or pursuant to one or more collective bargaining agreements under section 3(40) of ERISA. Neither Plan A’s relationship with a new organization of health care providers, nor the use of various media to publicize Plan A’s attractive benefits throughout the area served by Union A, alters Plan A’s status for the purpose of this section.

Example 9. Assume the same facts as in Example 7. Union A undertakes an area-wide organizing campaign among the employees of all the health care providers who belong to the Medical Consortium. When soliciting individual employees to sign up as union members, Union A distributes Plan A’s information materials and promises to bargain for the same coverage. At the same time, when appealing to the employers in the Medical Consortium for voluntary recognition, Union A promises to publicize the Consortium’s status as a group of unionized health care service providers. Union A eventually succeeds in obtaining recognition based on its majority status among the employees working for Medical Consortium employers. The Consortium, acting on behalf of its employer members, negotiates a collective bargaining agreement with Union A that provides terms and conditions of employment, including coverage under Plan A. In this example, Plan A still meets the criteria for a regulatory finding that it is collectively bargained under section 3(40) of ERISA. Union
§ 2510.3–101

A’s recruitment and representation of a new occupational category of workers unrelated to the construction trade, its promotion of attractive health benefits to achieve organizational success, and the Plan’s resultant growth, do not take Plan A outside the regulatory finding. Example 10. Assume the same facts as in Example 7. The Medical Consortium, a newly formed organization, approaches Plan A with a proposal to make money for Plan A and Union A by enrolling a large group of employers, their employees, and self-employed individuals affiliated with the Medical Consortium. The Medical Consortium obtains employers’ signatures on a generic document bearing Union A’s name, labeled “collective bargaining agreement,” which provides for health coverage under Plan A and compliance with wage and hour statutes, as well as other employment laws. Employees of signatory employers sign enrollment documents for Plan A and are issued membership cards in Union A; their membership dues are regularly checked off along with their monthly payments for health coverage. Self-employed individuals similarly receive union membership cards and make monthly payments, which are divided between Plan A and the Union. Aside from health coverage matters, these new participants have little or no contact with Union A. The new participants enrolled through the Consortium amount to 18% of the population of Plan A during the current Plan Year. In this example, Plan A now fails to meet the criteria in paragraphs (b)(2) and (b)(3) of this section, because more than 15% of its participants are individuals who are not employed under agreements that are the product of a bona fide collective bargaining relationship and who do not fall within any of the other nexus categories set forth in paragraph (b)(2) of this section. Moreover, even if the number of additional participants enrolled through the Medical Consortium, together with any other participants who did not fall within any of the nexus categories, did not exceed 15% of the total participant population under the plan, the circumstances in this example would trigger the disqualification of paragraph (c)(2) of this section, because Plan A now is being maintained under a substantial number of agreements that are a “scheme, plan, stratagem or artifice of evasion” intended primarily to evade compliance with state laws and regulations pertaining to insurance. In either case, the consequence of adding the participants through the Medical Consortium is that Plan A is now a MEWA for purposes of section 3(40) of ERISA and is not exempt from state regulation by virtue of ERISA.

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

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

(i) The entity is an operating company, or

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

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

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

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

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

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

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

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

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

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

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

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

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

(vi) Any restriction on substitution of an assignee as a limited partner of a partnership, including a general partner consent requirement, provided that the economic benefits of ownership of the assignor may be transferred or assigned without regard to such restriction or consent (other than compliance
§2510.3–101

with any other restriction described in this paragraph (b)(4) of this section:

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

(vii) Any limitation or restriction on transfer or assignment which is not created or imposed by the issuer or any person acting for or on behalf of such issuer.

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

(2) [Reserved]

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

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

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

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

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

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

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

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

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

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

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

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

(4)(i) An investment is a “derivative investment” for purposes of this paragraph (d) if it is—
(A) A venture capital investment as to which the investor’s management rights have ceased in connection with a public offering of securities of the operating company to which the investment relates, or
(B) An investment that is acquired by a venture capital operating company in the ordinary course of its business in exchange for an existing venture capital investment in connection with:
(1) A public offering of securities of the operating company to which the existing venture capital investment relates, or
(2) A merger or reorganization of the operating company to which the existing venture capital investment relates, provided that such merger or reorganization is made for independent business reasons unrelated to extinguishing management rights.

(ii) An investment ceases to be a derivative investment on the later of:
(A) 10 years from the date of the acquisition of the original venture capital investment to which the derivative investment relates, or
(B) 30 months from the date on which the investment becomes a derivative investment.

(5) For purposes of this paragraph (d) and paragraph (e)—
(i) An “initial valuation date” is the later of—
(A) Any date designated by the company within the 12 month period ending with the effective date of this section, or
(B) The first date on which an entity makes an investment that is not a short-term investment of funds pending long-term commitment.
(ii) An “annual valuation period” is a preestablished annual period, not exceeding 90 days in duration, which begins no later than the anniversary of an entity’s initial valuation date. An annual valuation period, once established may not be changed except for good cause unrelated to a determination under this paragraph (d) or paragraph (e).

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

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

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

(f) Participation by benefit plan investors. (1) Equity participation in an entity by benefit plan investors is “significant” on any date if, immediately after the most recent acquisition of any equity interest in the entity, 25 percent or more of the value of any class of equity interests in the entity is held by benefit plan investors (as defined in paragraph (f)(2)). For purposes of determinations pursuant to this paragraph (f), the value of any equity interests held by a person (other than a benefit plan investor) who has discretionary authority or control with respect to the assets of the entity or any person who provides investment advice for a fee (direct or indirect) with respect to such assets, or any affiliate of such a person, shall be disregarded.
(2) A “benefit plan investor” is any of the following—
   (i) Any employee benefit plan (as defined in section 3(3) of the Act), whether or not it is subject to the provisions of title I of the Act,
   (ii) Any plan described in section 4975(e)(1) of the Internal Revenue Code,
   (iii) Any entity whose underlying assets include plan assets by reason of a plan’s investment in the entity.

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

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

(h) Specific rules relating to plan investments. Notwithstanding any other provision of this section—
   (1) Except where the entity is an investment company registered under the Investment Company Act of 1940, when a plan acquires or holds an interest in any of the following entities its assets include its investment and an undivided interest in each of the underlying assets of the entity:
      (i) A group trust which is exempt from taxation under section 501(a) of the Internal Revenue Code pursuant to the principles of Rev. Rul. 81–100, 1981–1 C.B. 326,
      (ii) A common or collective trust fund of a bank,
      (iii) A separate account of an insurance company, other than a separate account that is maintained solely in connection with fixed contractual obligations of the insurance company under which the amounts payable, or credited, to the plan and to any participant or beneficiary of the plan (including an annuitant) are not affected in any manner by the investment performance of the separate account.
   (2) When a plan acquires or holds an interest in any entity (other than an insurance company licensed to do business in a State) which is established or maintained for the purpose of offering or providing any benefit described in section 3(1) or section 3(2) of the Act to participants or beneficiaries of the investing plan, its assets will include its investment and an undivided interest in the underlying assets of that entity.
   (3) When a plan or a related group of plans owns all of the outstanding equity interests (other than director’s qualifying shares) in an entity, its assets include those equity interests and all of the underlying assets of the entity. This paragraph (h)(3) does not apply, however, where all of the outstanding equity interests in an entity are qualifying employer securities described in section 407(d)(5) of the Act, owned by one or more eligible individual account plan(s) (as defined in section 407(d)(3) of the Act) maintained by the same employer, provided that substantially all of the participants in the plan(s) are, or have been, employed by the issuer of such securities or by members of a group of affiliated corporations (as determined under section 407(d)(7) of the Act) of which the issuer is a member.
   (4) For purposes of paragraph (h)(3), a “related group” of employee benefit plans consists of every group of two or more employee benefit plans—
      (i) Each of which receives 10 percent or more of its aggregate contributions from the same employer or from members of the same controlled group of corporations as determined under section 1563(a) of the Internal Revenue Code, without regard to section 1563(a)(4) thereof; or
      (ii) Each of which is either maintained by, or maintained pursuant to a collective bargaining agreement negotiated by, the same employee organization or affiliated employee organizations. For purposes of this paragraph, an “affiliate” of an employee organization means any person controlling, controlled by, or under common control with such organization, and includes any organization chartered by the same parent body, or governed by the same constitution and bylaws, or
§ 2510.3-101

Employee Benefits Security Admin., Labor

having the relation of parent and subordinate.

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

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

(i) The Government National Mortgage Association;

(ii) The Federal Home Loan Mortgage Corporation; or


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

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

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

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

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

(5) A plan, P, invests in a limited partnership, V, pursuant to a private offering. There is significant equity participation by benefit plan investors in V. Therefore, P’s assets include an undivided interest in the underlying assets of V.
plan investors in V. V acquires equity positions in the companies in which it invests, and, in connection with these investments, V negotiates terms that give it the right to participate in or influence the management of those companies. Some of these investments are in publicly-offered securities and some are in securities acquired in private offerings. During the period, more than 50 percent of V’s assets, valued at cost, consisted of investments with respect to which V obtained management rights of the kind described above, V’s management consults and advises, the management of only one portfolio company with respect to which it has management rights, although it devotes substantial resources to its consultations with that company. With respect to the other portfolio companies, V relies on the managers of other entities to consult with and advise the companies’ management. V is a venture capital operating company and therefore P has acquired its limited partnership investment, but has not acquired an interest in any of the underlying assets of V. Thus, none of the managers of V would be fiduciaries with respect to P solely by reason of its investment. In this situation, the mere fact that V does not participate in or influence the management of all its portfolio companies does not affect its characterization as a venture capital operating company.

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

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

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

(9) A plan, P, acquires a limited partnership interest in X pursuant to a private offering. There is significant equity participation in X by benefit plan investors. X is engaged in the business of making “convertible loans” which are structured as follows: X lends a specified percentage of the cost of acquiring real property to a borrower who provides the remaining capital needed to make the acquisition. This loan is secured by a mortgage on the property. Under the terms of the loan, X is entitled to receive a fixed rate of interest payable out of the initial cash flow from the property and is also entitled to that portion of any additional cash flow which is equal to the percentage of the acquisition cost that is financed by its loan. Simultaneously with the making of the loan, the borrower also gives X an option to purchase an interest in the property for the original principal amount of the loan at the expiration of its initial term. X’s percentage interest in the property, if it exercises this option, would be equal to the percentage of the acquisition cost of the property which is
(10) In a private transaction, a plan, P, acquires a 30 percent participation in a debt instrument that is held by a bank. Since the value of the participation certificate relates solely to the debt instrument, that debt instrument is, under paragraph (g), treated as the sole asset of a separate entity. Equity participation in that entity by benefit plan investors is significant since the value of the plan’s participation exceeds 25 percent of the value of the instrument. In addition, the hypothetical entity is not an operating company because it is primarily engaged in the investment of capital (i.e., holding the debt instrument). Thus, P’s assets include the participation and an undivided interest in the debt instrument, and the bank is a fiduciary of P to the extent it exercises discretionary authority or control over such property.

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

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

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

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

[51 FR 47225, Dec. 31, 1986]
(2) Safe harbor. (i) For purposes of paragraph (a)(1) of this section, in the case of a plan with fewer than 100 participants at the beginning of the plan year, any amount deposited with such plan not later than the 7th business day following the day on which such amount is received by the employer (in the case of amounts that a participant or beneficiary pays to an employer), or the 7th business day following the day on which such amount would otherwise have been payable to the participant in cash (in the case of amounts withheld by an employer from a participant’s wages), shall be deemed to be contributed or repaid to such plan on the earliest date on which such contributions or participant loan repayments can reasonably be segregated from the employer’s general assets.

(ii) This paragraph (a)(2) sets forth an optional alternative method of compliance with the rule set forth in paragraph (a)(1) of this section. This paragraph (a)(2) does not establish the exclusive means by which participant contribution or participant loan repayment amounts shall be considered to be contributed or repaid to a plan by the earliest date on which such contributions or repayments can reasonably be segregated from the employer’s general assets.

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

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

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

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

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

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

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

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

(iii) Within 5 business days after the end of such extension period, provides a copy of the notice required under paragraph (d)(1)(i) of this section to the Secretary, along with a certification

VerDate Sep<11>2014 11:45 Oct 07, 2015 Jkt 235124 PO 00000 Frm 00480 Fmt 8010 Sfmt 8010 Y:

29 CFR Ch. XXV (7–1–15 Edition)
that such notice was provided to the participants and that the bond or letter of credit required under paragraph (d)(1)(ii) of this section was obtained.

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

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

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

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

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

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

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

(1) Employer A sponsors a 401(k) plan. There are 30 participants in the 401(k) plan. A has one payroll period for its employees and uses an outside payroll processing service to pay employee wages and process deductions. A has established a system under which the payroll processing service provides payroll deduction information to A within 1 business day after the issuance of paychecks. A checks this information for accuracy within 5 business days and then forwards the withheld employee contributions to the plan. The amount of the total withheld employee contributions is deposited with the trust that is maintained under the plan on the 7th business day following the date on which the employees are paid. Under the safe harbor in paragraph (a)(2) of this section, when the participant contributions are deposited with the plan on the 7th business day following a pay date, the participant contributions are deemed to be contributed to the plan on the earliest date on which such contributions can reasonably be segregated from A’s general assets.

(2) Employer B is a large national corporation which sponsors a 401(k) plan with 600 participants. B has several payroll centers and uses an outside payroll processing service to pay employee wages and process deductions. Each payroll center has a different pay period. Each center maintains separate accounts on its books for purposes of accounting for that center’s payroll deductions and provides the outside payroll processor the data necessary to prepare employee paychecks and process deductions. The payroll processing service issues the employees’ paychecks and deducts all payroll taxes and elective employee deductions. The payroll processing service forwards the employee payroll deduction data to B on the date of issuance of paychecks. B checks this data for accuracy and transmits this data along with the employee 401(k) deferral funds to the plan’s investment firm within 3 business days. The plan’s investment firm deposits the employee 401(k) deferral funds into the plan on the day received from B. The assets of B’s 401(k) plan would include the participant contributions no later than 3 business days after the issuance of paychecks.

(3) Employer C sponsors a self-insured contributory group health plan with 90 participants. Several former employees have elected, pursuant to the provisions of ERISA section 602, 29 U.S.C. 1162, to pay C for continuation of their coverage under the plan. These checks arrive at various times during
the month and are deposited in the employer’s general account at bank Z. Under paragraphs (a) and (c) of this section, the assets of the plan include the former employees’ payments as soon after the checks have cleared the bank as C could reasonably be expected to segregate the payments from its general assets, but in no event later than 90 days after the date on which the former employees’ participant contributions are received by C. If, however, C deposits the former employees’ payments with the plan no later than the 7th business day following the day on which they are received by C, the former employees’ participant contributions will be deemed to be contributed to the plan on the earliest date on which such contributions can reasonably be segregated from C’s general assets.

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

(h) Applicability date for collectively-bargained plans. (1) Paragraph (b) of this section applies to collectively bargained plans no sooner than the later of—
   (i) February 3, 1997; or
   (ii) The first day of the plan year that begins after the expiration of the last to expire of any applicable bargaining agreement in effect on August 7, 1996.

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

   (i) Optional postponement of applicability. (1) The application of paragraph (b) of this section shall be postponed for up to an additional 90 days beyond the effective date described in paragraph (g) of this section for an employer who, prior to February 3, 1997—
      (i) Provides a true and accurate written notice, distributed in a manner designed to reach all the plan participants before the end of February 3, 1997, stating—
         (A) That the employer elected to postpone such applicability;
         (B) The date that the postponement will expire; and
         (C) With particularity the reasons why the employer cannot reasonably segregate the participant contributions within the time period described in paragraph (b) of this section, by February 3, 1997;
      (ii) Obtains a performance bond or irrevocable letter of credit in favor of the plan and in an amount of not less than the total amount of participant contributions received or withheld by the employer in the previous 3 months;
      (iii) Provides a copy of the notice required under paragraph (i)(1)(i) of this section to the Secretary, along with a certification that such notice was provided to the participants and that the bond or letter of credit required under paragraph (i)(1)(ii) of this section was obtained; and
      (iv) For each month during which such postponement is in effect, provides a true and accurate written notice to the plan participants indicating the date on which the participant contributions received or withheld by the employer during such month were transmitted to the plan.

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

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

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

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

PART 2520—RULES AND REGULATIONS FOR REPORTING AND DISCLOSURE

Subpart A—General Reporting and Disclosure Requirements

Sec. 2520.101–1 Duty of reporting and disclosure.
2520.101–2 Filing by multiple employer welfare arrangements and certain other related entities.
2520.101–3 Notice of blackout periods under individual account plans.
2520.101–4 [Reserved]
2520.101–5 Annual funding notice for defined benefit pension plans.
2520.101–6 Multiemployer pension plan information made available on request.

Subpart B—Contents of Plan Descriptions and Summary Plan Descriptions

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

Subpart C—Annual Report Requirements

2520.103–1 Contents of the annual report.
2520.103–2 Contents of the annual report for a group insurance arrangement.
2520.103–3 Exemption from certain annual reporting requirements for assets held in a common or collective trust.
2520.103–4 Exemption from certain annual reporting requirements for assets held in an insurance company pooled separate account.
2520.103–5 Transmittal and certification of information to plan administrator for annual reporting purposes.
2520.103–6 Definition of reportable transaction for Annual Return/Report.
2520.103–7 Limitation on scope of accountant’s examination.
2520.103–9 Direct filing for bank or insurance carrier trusts and accounts.
2520.103–10 Annual report financial schedules.
2520.103–11 Assets held for investment purposes.
2520.103–12 Limited exemption and alternative method of compliance for annual reporting of investments in certain entities.
2520.103–13 Special terminal report for abandoned plans.

Subpart D—Provisions Applicable to Both Reporting and Disclosure Requirements

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

§ 2520.104a–1 Filing with the Secretary of Labor.

§ 2520.104a–2 Electronic filing of annual reports.

§ 2520.104a–3—2520.104a–4 [Reserved]

§ 2520.104a–5 Annual report filing requirements.

§ 2520.104a–6 Annual reporting for plans which are part of a group insurance arrangement.

§ 2520.104a–7 [Reserved]

§ 2520.104a–8 Requirement to furnish documents to the Secretary of Labor on request.

Subpart F—Disclosure Requirements

§ 2520.104b–1 Disclosure.

§ 2520.104b–2 Summary plan description.

§ 2520.104b–3 Summary of material modifications to the plan and changes in the information required to be included in the summary plan description.

§ 2520.104b–4 Alternative methods of compliance for furnishing the summary plan description and summaries of material modifications of a pension plan to a retired participant, a separated participant with vested benefits, and a beneficiary receiving benefits.

§ 2520.104b–10 Summary Annual Report.

§ 2520.104b–30 Charges for documents.

Subpart G—Recordkeeping Requirements

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

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


§ 2520.101–2 Filing by multiple employer welfare arrangements and certain other related entities.

(a) Basis and scope. Section 101(g) of the Employee Retirement Income Security Act (ERISA), as amended by the Patient Protection and Affordable Care Act, requires the Secretary of Labor (the Secretary) to establish, by regulation, a requirement that multiple employer welfare arrangements (MEWAs) providing benefits that consist of medical care (as described in paragraph (b)(6) of this section), which are not group health plans, to register with the Secretary prior to operating in a State. Section 101(g) also permits the Secretary to require, by regulation, such MEWAs to report, not more frequently than annually, in such form and manner as the Secretary may require, for the purpose of determining the extent to which the requirements of part 7 of subtitle B of title I of ERISA (part 7) are being carried out in connection with such benefits. Section 734 of ERISA provides that the Secretary may promulgate such regulations as may be necessary or appropriate to carry out the provisions of part 7. This section sets out requirements for reporting by MEWAs that provide benefits that consist of medical care and by certain entities that claim not to be a MEWA solely due to the exception in section 3(40)(A)(i) of ERISA (referred to in this section as Entities Claiming Exception or ECEs). The reporting requirements apply regardless of whether the MEWA or ECE is a group health plan.

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

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

(2) Group health plan means a plan that is a group insurance arrangement or a group health reimbursement arrangement, and the term includes any plan described in section 3(40)(A)(i) of ERISA (referred to in this section as Entities Claiming Exception or ECEs). The reporting requirements apply regardless of whether the MEWA or ECE is a group health plan.

The procedures for implementing the plan administrator’s duty of reporting to the Secretary of Labor and disclosing information to participants and beneficiaries are located in subparts D, E and F of this part.
(iii) In the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot be identified, jointly and severally, the person or persons actually responsible (whether or not so designated under the terms of the instrument under which the MEWA or ECE is operated) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent, custodian, or trustee designated by such person or persons.

(2) Entity Claiming Exception (ECE) means an entity that claims it is not a MEWA on the basis that the entity is established or maintained pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements within the meaning of section 3(40)(A)(i) of ERISA and §2510.3–40.

(3) Excepted benefits means excepted benefits within the meaning of section 733(c) of ERISA and §2590.701–2 of this chapter.

(4) Group health plan means a group health plan within the meaning of section 733(a) of ERISA and §2590.701–2 of this chapter.

(5) Health insurance issuer means a health insurance issuer within the meaning of section 733(b)(2) of ERISA and §2590.701–2 of this chapter.

(6) Medical care means medical care within the meaning of section 733(a)(2) of ERISA and §2590.701–2 of this chapter.

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

(8) Operating means any activity including but not limited to marketing, soliciting, providing, or offering to provide benefits consisting of medical care.

(9) Origination means, with regard to an ECE, the occurrence of any of the following events (an ECE is considered to have been originated only when an event described below occurs)—

(i) The ECE begins operating with regard to the employees of two or more employers (including one or more self-employed individuals);

(ii) The ECE begins operating following a merger with another ECE (unless all of the ECEs that participate in the merger previously were last originated at least three years prior to the merger); or

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

(10) Reporting or to report means to file the Form M–1 as required pursuant to sections 101(g) of ERISA; §2520.101–2; or the instructions to the Form M–1.

(11) Special filing event means, with regard to an ECE—

(i) The ECE begins knowingly operating in any additional State or States that were not indicated on a previous report filed pursuant to paragraph (e)(1)(i) or (f)(2)(i) of this section; or

(ii) The ECE experiences a material change as defined in the Form M–1 instructions.

(12) State means State within the meaning of §2590.701–2 of this chapter.

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

(i) The administrator of a MEWA regardless of whether the entity is a group health plan; and

(ii) The administrator of an ECE during the three-year period following an event described in paragraph (b)(9) of this section.

(2) Exceptions—(1) Nothing in this paragraph (c) shall be construed to require reporting under this section by the administrator of a MEWA or ECE described under this paragraph (c)(2)(i).

(A) A MEWA or ECE licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees;

(B) A MEWA or ECE that provides coverage that consists solely of excepted benefits, which are not subject to ERISA part 7. If the MEWA or ECE provides coverage that consists of both
excepted benefits and other benefits for medical care that are not excepted benefits, the administrator of the MEWA or ECE is required to report under this section;

(C) A MEWA or ECE that is a group health plan not subject to ERISA, including a governmental plan, church plan, or a plan maintained solely for the purpose of complying with workmen’s compensation laws, within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively; or

(D) A MEWA or ECE that provides coverage only through group health plans that are not covered by ERISA, including governmental plans, church plans, or plans maintained solely for the purpose of complying with workmen’s compensation laws within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively (or other arrangements not covered by ERISA, such as health insurance coverage offered to individuals other than in connection with a group health plan, known as individual market coverage).

(ii) Nothing in this paragraph (c) shall be construed to require reporting under this section by the administrator of an entity that would not constitute a MEWA or ECE but for the following circumstances under this paragraph (c)(2)(ii).

(A) The entity provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25 percent at any time during the plan year, applying principles similar to the principles under section 414(c) of the Internal Revenue Code;

(B) The entity provides coverage to the employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that occurs for a purpose other than avoiding Form M–1 filing and is temporary in nature. For purposes of this paragraph, “temporary” means the MEWA or ECE does not extend beyond the end of the plan year following the plan year in which the change in control occurs; or

(C) The entity provides coverage to persons (excluding spouses and dependents) who are not employees or former employees of the plan sponsor, such as non-employee members of the board of directors or independent contractors, and the number of such persons who are not employees or former employees does not exceed one percent of the total number of employees or former employees covered under the arrangement, determined as of the last day of the year to be reported or, determined as of the 60th day following the date the MEWA or ECE began operating in a manner such that a filing is required pursuant to paragraph (e)(1)(i), (2), or (3) of this section.

(3) Examples. The rules of this paragraph (c) are illustrated by the following examples:

Example 1. (i) Facts. MEWA A begins operating by offering coverage to the employees of two or more employers on August 1, 2013. MEWA A is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

(ii) Conclusion. In this Example 1, the administrator of MEWA A is not required to report via Form M–1. MEWA A meets the exception to the filing requirement in paragraph (c)(2)(i)(A) of this section because it is licensed or authorized to operate as a health insurance issuer in every State in which it offers coverage for medical care to employees.

Example 2. (i) Facts. Company B maintains a group health plan that provides benefits for medical care for its employees (and their dependents). Company B establishes a joint venture in which it has a 25 percent stock ownership interest, determined by applying the principles similar to the principles under section 414(c) of the Internal Revenue Code, and transfers some of its employees to the joint venture. Company B continues to cover these transferred employees under its group health plan.

(ii) Conclusion. In this Example 2, the administrator is not required to file the Form M–1 because Company B’s group health plan meets the exception to the filing requirement in paragraph (c)(2)(i)(A) of this section. This is because Company B’s group health plan would not constitute a MEWA but for the fact that it provides coverage to two or more trades or businesses that share a common control interest of at least 25 percent.

Example 3. (i) Facts. Company C maintains a group health plan that provides benefits for medical care for its employees. The plan year of Company C’s group health plan is the fiscal year for Company C, which is October 1st—September 30th. Therefore, October 1, 2012—September 30, 2013 is the 2013 plan year. Company C decides to sell a portion of its
business. Division Z, to Company D. Company C signs an agreement with Company D under which Division Z will be transferred to Company D, effective September 30, 2013. The change in control of Division Z therefore occurs on September 30, 2013. Under the terms of the agreement, Company C agrees to continue covering all of the employees that formerly worked for Division Z under its group health plan until Company D has established a new group health plan to cover these employees. Under the terms of the agreement, it is anticipated that Company C will not be required to cover the employees of Division Z under its group health plan beyond the end of the 2014 plan year, which is the plan year following the plan year in which the change in control of Division Z occurred.

(ii) Conclusion. In this Example 3, the administrator of Company C’s group health plan is not required to report via the Form M–1 on March 1, 2014 for fiscal year 2013 because it is subject to the exception to the filing requirement in paragraph (c)(2)(ii)(B) of this section for an entity that would not constitute a MEWA but for the fact that it is created by a change in control of businesses that occurs for a purpose other than to avoid filing the Form M–1 and is temporary in nature. Under the exception, “temporary” means the MEWA does not extend beyond the end of the plan year following the plan year in which the change in control occurs. The administrator is not required to file the 2013 Form M–1 annual report because it is anticipated that Company C will not be required to cover the employees of Division Z under its group health plan beyond the end of the 2014 plan year, which is the plan year following the plan year in which the change in control of businesses occurred.

Example 4. (i) Facts. Company E maintains a group health plan that provides benefits for medical care for its employees (and their dependents) as well as certain independent contractors who are self-employed individuals. The plan is therefore a MEWA. The administrator of Company E’s group health plan determines that the number of independent contractors covered under the group health plan as of the last day of calendar year 2013 is less than one percent of the total number of employees and former employees covered under the plan determined as of the last day of calendar year 2013.

(ii) Conclusion. In this Example 4, the administrator of Company E’s group health plan is not required to report via the Form M–1 for calendar year 2013 (a filing that is otherwise due by March 1, 2014) because it is subject to the exception to the filing requirement provided in paragraph (c)(2)(ii)(C) of this section for entities that cover a very small number of persons who are not employees or former employees of the plan sponsor.

(d) Information to be reported—(1) Any reporting required by this section shall consist of a completed copy of the Form M–1 Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs) (Form M–1) and any additional statements required pursuant to the instructions for the Form M–1.

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

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

(e) Origination, registration, and other non-annual reporting requirements and timing—(1) General rule for ECEs—(i) Except as provided in paragraph (e)(1)(ii) of this section, and subject to the limitations established by paragraph (c)(1)(ii) of this section, when an ECE experiences an event described in paragraphs (b)(9) or (b)(11) of this section, the administrator of the ECE shall file Form M–1 by the 30th day following the date of the event.

(ii) Exception. Paragraph (e)(1)(i) of this section does not apply to ECEs that experience an origination as described in paragraph (b)(9)(i) of this section. Such entities are required, subject to the limitations established by paragraph (c)(1)(ii) of this section, to file the Form M–1 30 days prior to the date of the event.

(2) General rule for MEWAs—(i) In general. Except as provided in paragraph (e)(2)(i) of this section, the administrator of the MEWA is required to register with the Secretary by filing the Form M–1 30 days prior to operating in any State.

(ii) Exception. Paragraph (e)(2)(i) of this section does not apply to MEWAs that, prior to the effective date of this section, were already in operation in a
State (or States). Such entities are required to submit an annual filing pursuant to annual reporting rules described in paragraph (f)(2)(i) of this section for that State (or those States).

(3) Special rule requiring MEWAs to make additional filings. Subsequent to registering with the Secretary pursuant to paragraph (e)(2)(i) of this section, the administrator of a MEWA shall file the Form M–1:

(i) Within 30 days of knowingly operating in any additional State or States that were not indicated on a previous report filed pursuant to paragraph (e)(2)(i) or (f)(2)(i) of this section;

(ii) Within 30 days of the MEWA operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA;

(iii) Within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year; or

(iv) Within 30 days of experiencing a material change as defined in the Form M–1 instructions.

(4) Anti-abuse rule. If a MEWA or ECE neither offers nor provides benefits consisting of medical care within a State during the calendar year immediately following the year in which a filing is made by the ECE pursuant to paragraph (e)(1) of this section (due to an event described in paragraph (b)(9)(i) or (b)(11)(i) of this section) or a filing is made by the MEWA pursuant to paragraph (e)(2) or (3) of this section, with respect to operating in such State, such filing will be considered to have lapsed.

(5) Multiple filings not required in certain circumstances. If multiple filings are required under this paragraph (e), a single filing will satisfy this section so long as the filing is timely for each required filing.

(6) Extensions. (i) An extension may be granted for filing a report required by paragraph (e)(1), (2), or (3) of this section if the administrator complies with the extension procedure prescribed in the instructions to the Form M–1.

(ii) If the filing deadline set forth in this paragraph (e) is a Saturday, Sunday, or federal holiday, the form must be filed no later than the next business day.

(7) Annual reporting requirements and timing—(1) Period for which reporting is required. A completed copy of the Form M–1 is required to be filed for each calendar year during all or part of which the MEWA is operating and for each of the three calendar years following an origination during all or part of which the MEWA is operating.

(2) Filing deadline—(i) General March 1 filing due date for annual filings. Except as provided in paragraph (f)(2)(ii) of this section, a completed copy of the Form M–1 is required to be filed on or before each March 1 that follows a period for which reporting is required (as described in paragraph (f)(1) of this section).

(ii) Exception. Paragraph (f)(2)(i) of this section does not apply to ECEs and MEWAs if, between October 1 and December 31, the entity is required to make a filing pursuant to paragraph (e)(1), (2), or (3) of this section and makes that filing timely.

(3) Extensions. (i) An extension may be granted for filing a report required by paragraph (f)(2)(i) of this section if the administrator complies with the extension procedure prescribed in the instructions to the Form M–1.

(ii) If the filing deadline set forth in this paragraph (f) is a Saturday, Sunday, or federal holiday, the form must be filed no later than the next business day.

(4) Examples. The rules of paragraphs (e) and (f) of this section are illustrated by the following examples:

Example 1. (i) Facts. MEWA A began offering coverage for medical care to the employees of two or more employers on July 1, 2003 (and continues to offer such coverage). MEWA A has satisfied all filing requirements to date.

(ii) Conclusion. In this Example 1, the administrator of MEWA A must continue to file a timely completed Form M–1 annual report each year, but the administrator is not required to register with the Secretary because MEWA A meets the exception to the registration requirement in paragraph (e)(2)(ii) of this section and has not experienced any event described in paragraph (e)(3) that would require registering with the Secretary.
Example 2. (i) Facts. On August 25, 2013, MEWA B is operating in State P and has made all appropriate filings related to those operations. On December 22, 2013 one of the employers of two or more employers in MEWA B is awarded a new contract in State Q. The employer adds an office in State Q and the employees there are eligible to access its group health insurance plan beginning on January 1, 2014.

(ii) Conclusion. In this Example 2, the administrator of MEWA B must report the addition of State Q by filing the Form M–1 within 30 days of knowing that it is operating in State Q.

Example 3. (i) Facts. As of July 1, 2013, MEWA C is preparing to operate in States Y and Z. MEWA C is not licensed or authorized to operate as a health insurance issuer in any State and does not meet any of the other exceptions set forth in paragraph (c)(2) of this section.

(ii) Conclusion. In this Example 3, the administrator of MEWA C is required to register with the Secretary by filing a completed Form M–1 30 days prior to operating in States Y or Z. The administrator of MEWA C must also report any operations in States Y or Z by every March 1 thereafter.

Example 4. (i) Facts. As of July 28, 2013, MEWA D is operating in States V and W. MEWA D has satisfied the requirements of (e)(2) and, if applicable, (e)(3) with respect to those States. MEWA D is not licensed or authorized to operate as a health insurance issuer in any State and does not meet any of the other exceptions set forth in (c)(2) of this section. On August 5, 2013 MEWA D knowingly begins operating in State X.

(ii) Conclusion. In this Example 4, the administrator of MEWA D is required to make an additional registration filing with the Secretary by September 4, 2013 (within 30 days of knowingly operating in State X). Additionally, the administrator of MEWA D must continue to file the Form M–1 annually by every March 1 thereafter.

Example 5. (i) Facts. ECE A began offering coverage for medical care to the employees of two or more employers on January 1, 2007 and ECE A has not been involved in any mergers or experienced any other origination as described in paragraph (b)(9) of this section.

(ii) Conclusion. In this Example 5, ECE A was originated on January 1, 2007 and has not been originated since then. Therefore, the administrator of ECE A is not required to file a 2012 Form M–1 because the last time the ECE A was originated was January 1, 2007 which is more than three years prior. Further, the ECE has satisfied its reporting requirements by making three timely annual filings after its origination.

Example 6. (i) Facts. ECE B wants to begin offering coverage for medical care to the employees of two or more employers on July 1, 2013.

(ii) Conclusion. In this Example 6, the administrator of ECE B must file a completed Form M–1 on or before June 1, 2013 (which is 30 days prior to the origination date). In addition, the administrator of ECE B must file an updated copy of the Form M–1 by March 1, 2014 because the last date ECE B was originated was July 1, 2013 (which is less than three years prior to the March 1, 2014 due date). Furthermore, the administrator of ECE B must file the Form M–1 by March 1, 2015 and again by March 1, 2016 (because July 1, 2013 is less than three years prior to March 1, 2015 and March 1, 2016, respectively). However, if ECE B is not involved in any mergers and does not experience any other origination as described in paragraph (b)(9) of this section, there would not be a new origination date and no Form M–1 is required to be filed after March 1, 2016.

Example 7. (i) Facts. ECE D, which currently operates in State A and is still within the three-year window following its origination and the timely filing related thereto, is making preparations to operate in State B beginning on November 1, 2013.

(ii) Conclusion. In this Example 7, by operating in State B, ECE D experiences a special event within the three-year window following its origination and must make a filing by December 2, 2013.

Example 8. (i) Facts. Same facts as Example 7.

(ii) Conclusion. ECE D satisfied its special filing requirement but is unsure about its annual filing requirements.


(ii) Conclusion. In this Example 8, because MEWA E began operating on August 31, 2013, the administrator of MEWA E must register with the Secretary by filing a completed Form M–1 on or before August 1, 2013 (30 days prior to operating in any State). In addition, the administrator of MEWA E must file the Form M–1 annually by every March 1 thereafter.

Example 10. (i) Facts. Same facts as Example 9, but MEWA E registers on or before August 1, 2013 by filing a Form M–1 indicating it will begin operating in every State. However, in the calendar year immediately following the filing, MEWA E only offered or provided benefits consisting of medical care to participants in State Z.

(ii) Conclusion. In this Example 10, the registration for all States (other than State Z) have lapsed under (e)(4) because MEWA E only offered or provided benefits consisting of medical care to participants in State Z in
§2520.101–3 Notice of blackout periods under individual account plans.

(a) In general. In accordance with section 101(i) of the Act, the administrator of an individual account plan, within the meaning of paragraph (d)(2) of this section, shall provide notice of any blackout period, within the meaning of paragraph (d)(1) of this section, to all participants and beneficiaries whose rights under the plan will be temporarily suspended, limited, or restricted by the blackout period (the “affected participants and beneficiaries”) and to issuers of employer securities subject to such blackout period in accordance with this section.

(b) Notice to participants and beneficiaries—(1) Content. The notice required by paragraph (a) of this section shall be written in a manner calculated to be understood by the average plan participant and shall include—

(i) The reasons for the blackout period;

(ii) A description of the rights otherwise available to participants and beneficiaries under the plan that will be temporarily suspended, limited or restricted by the blackout period (e.g., right to direct or diversify assets in individual accounts, right to obtain loans from the plan, right to obtain distributions from the plan), including identification of any investments subject to the blackout period;

(iii) The length of the blackout period by reference to:

(A) The expected beginning date and ending date of the blackout period; or

(B) The calendar week during which the blackout period is expected to begin and end, provided that during such weeks information as to whether the blackout period has begun or ended is readily available, without charge, to affected participants and beneficiaries, such as via a toll-free number or access to a specific web site, and the notice describes how to access the information;

(iv) In the case of investments affected, a statement that the participant or beneficiary should evaluate the appropriateness of their current investment decisions in light of their inability to direct or diversify assets in their accounts during the blackout period (a notice that includes the advisory statement contained in paragraph 4. of the model notice in paragraph (e)(2) of this section will satisfy this requirement);

(v) In any case in which the notice required by paragraph (a) of this section is not furnished at least 30 days in advance of the last date on which affected participants and beneficiaries could exercise affected rights immediately before the commencement of the blackout period, except for a notice furnished pursuant to paragraph (b)(2)(i)(C) of this section:

(A) A statement that Federal law generally requires that notice be furnished to affected participants and beneficiaries at least 30 days in advance of the last date on which participants and beneficiaries could exercise the affected rights immediately before

the calendar year immediately following the filing. If subsequently, MEWA E begins offering or providing benefits consisting of medical care to participants in any additional State (or States), it must make a new registration filing pursuant to (e)(3) of this section.

(g) Electronic filing. A completed Form M–1 is filed with the Secretary by submitting it electronically as prescribed in the instructions to the Form M–1.

(h) Penalties—(1) Civil penalties and procedures. For information on civil penalties under section 502(c)(5) of ERISA for persons who fail to file the information required under this section, see §2560.502c–5 of this chapter. For information relating to administrative hearings and appeals in connection with the assessment of civil penalties under section 502(c)(5) of ERISA, see §§2570.90 through 2570.101 of this chapter.

(2) Criminal penalties and procedures. For information on criminal penalties under section 519 of ERISA for persons who knowingly make false statements or false representation of fact with regards to the information required under this section, see section 501(b) of ERISA.

(3) Cease and desist and summary seizure orders. For information on the Secretary’s authority to issue a cease and desist or summary seizure order under section 521 of ERISA, see §2560.521.

[78 FR 13792, Mar. 1, 2013]
the commencement of a blackout period (a notice that includes the statement contained in paragraph 5. of the model notice in paragraph (e)(2) of this section will satisfy this requirement), and

(B) An explanation of the reasons why at least 30 days advance notice could not be furnished; and

(vi) The name, address and telephone number of the plan administrator or other contact responsible for answering questions about the blackout period.

(2) Timing. (i) The notice described in paragraph (a) of this section shall be furnished to all affected participants and beneficiaries at least 30 days, but not more than 60 days, in advance of the last date on which such participants and beneficiaries could exercise the affected rights immediately before the commencement of any blackout period.

(ii) The requirement to give at least 30 days advance notice contained in paragraph (b)(2)(i) of this section shall not apply in any case in which—

(A) A deferral of the blackout period in order to comply with paragraph (b)(2)(i) of this section would result in a violation of the requirements of section 404(a)(1)(A) or (B) of the Act, and a fiduciary of the plan reasonably so determines in writing;

(B) The inability to provide the advance notice of a blackout period is due to events that were unforeseeable or circumstances beyond the reasonable control of the plan administrator, and a fiduciary of the plan reasonably so determines in writing; or

(C) The blackout period applies only to one or more participants or beneficiaries solely in connection with their becoming, or ceasing to be, participants or beneficiaries of the plan as a result of a merger, acquisition, divestiture, or similar transaction involving the plan or plan sponsor.

(iii) In any case in which paragraph (b)(2)(i) of this section applies, the administrator shall furnish the notice described in paragraph (a) of this section to all affected participants and beneficiaries as soon as reasonably possible under the circumstances, unless such notice in advance of the termination of the blackout period is impracticable.

(iv) Determinations under paragraph (b)(2)(ii)(A) and (B) of this section must be dated and signed by the fiduciary.

(3) Form and manner of furnishing notice. The notice required by paragraph (a) of this section shall be in writing and furnished to affected participants and beneficiaries in any manner consistent with the requirements of §2520.104b–1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(4) Changes in length of blackout period. If, following the furnishing of a notice pursuant to this section, there is a change in the length of the blackout period (specified in such notice pursuant to paragraph (b)(1)(iii) of this section), the administrator shall furnish all affected participants and beneficiaries an updated notice explaining the reasons for the change and identifying all material changes in the information contained in the prior notice. Such notice shall be furnished to all affected participants and beneficiaries as soon as reasonably possible, unless such notice in advance of the termination of the blackout period is impracticable.

(c) Notice to issuer of employer securities. (1) The notice required by paragraph (a) of this section shall be furnished to the issuer of any employer securities held by the plan and subject to the blackout period. Such notice shall contain the information described in paragraph (b)(1)(i), (ii), (iii) and (vi) of this section and shall be furnished in accordance with the time frames prescribed in paragraph (b)(2) of this section. In the event of a change in the length of the blackout period specified in such notice, the plan administrator shall furnish an updated notice to the issuer in accordance with the requirements of paragraph (b)(4) of this section.

(2) For purposes of this section, notice to the agent for service of legal process for the issuer shall constitute notice to the issuer, unless the issuer has provided the plan administrator with the name of another person for service of notice, in which case the plan administrator shall furnish notice to such person. Such notice shall be in writing, except that the notice may be
in electronic or other form to the extent the person to whom notice must be furnished consents to receive the notice in such form.

(3) If the issuer designates the plan administrator as the person for service of notice pursuant to paragraph (c)(2) of this section, the issuer shall be deemed to have been furnished notice on the same date as notice is furnished to affected participants and beneficiaries pursuant to paragraph (b) of this section.

(d) Definitions. For purposes of this section—

(1) Blackout period—(i) General. The term "blackout period" means, in connection with an individual account plan, any period for which any ability of participants or beneficiaries under the plan, which is otherwise available under the terms of such plan, to direct or diversify assets credited to their accounts, to obtain loans from the plan, or to obtain distributions from the plan is temporarily suspended, limited, or restricted, if such suspension, limitation, or restriction is for any period of more than three consecutive business days.

(ii) Exclusions. The term "blackout period" does not include a suspension, limitation, or restriction—

(A) Which occurs by reason of the application of the securities laws (as defined in section 3(a)(47) of the Securities Exchange Act of 1934);

(B) Which is a regularly scheduled suspension, limitation, or restriction under the plan (or change thereto), provided that such suspension, limitation or restriction (or change) has been disclosed to affected plan participants and beneficiaries through the summary plan description, materials describing specific investment alternatives under the plan and limits thereon or any changes thereto, participation or enrollment forms, or any other documents and instruments pursuant to which the plan is established or operated that have been furnished to such participants and beneficiaries;

(C) Which occurs by reason of a qualified domestic relations order or by reason of a pending determination (by a court of competent jurisdiction or otherwise) whether a domestic relations order filed (or reasonably anticipated to be filed) with the plan is a qualified order within the meaning of section 206(d)(3)(B)(i) of the Act; or

(D) Which occurs by reason of an act or a failure to act on the part of an individual participant or by reason of an action or claim by a party unrelated to the plan involving the account of an individual participant.

(2) Individual account plan. The term "individual account plan" shall have the meaning provided such term in section 3(34) of the Act, except that such term shall not include a "one-participant retirement plan" within the meaning of paragraph (d)(3) of this section.

(3) One-participant retirement plan. The term "one-participant retirement plan" means a one-participant retirement plan as defined in section 101(i)(8)(B) of the Act.

(4) Issuer. The term “issuer” means an issuer as defined in section 3 of the Securities Exchange Act of 1934 (15 U.S.C. 78c), the securities of which are registered under section 12 of the Securities Exchange Act of 1934, or that is required to file reports under section 15(d) of the Securities Exchange Act of 1934, or files or has filed a registration statement that has not yet become effective under the Securities Act of 1933 (15 U.S.C. 77a et seq.), and that it has not withdrawn.

(5) Calendar week. For purposes of paragraph (b)(1)(ii)(B), the term "calendar week" means a seven day period beginning on Sunday and ending on Saturday.

(e) Model notice—(1) General. The model notice set forth in paragraph (e)(2) of this section is intended to assist plan administrators in discharging their notice obligations under this section. Use of the model notice is not mandatory. However, a notice that uses the statements provided in paragraphs 4. and 5.(A) of the model notice will be deemed to satisfy the notice content requirements of paragraph (b)(1)(iV) and (b)(1)(v)(A), respectively, of this section. With regard to all other information required by paragraph (b)(1) of this section, compliance with the notice content requirements will depend on the facts and circumstances.
pertaining to the particular blackout period and plan.

(2) Form and content of model notice.

Important Notice Concerning Your Rights

[Enter date of notice]

1. This notice is to inform you that the [enter name of plan] will be [enter reasons for blackout period, as appropriate: changing investment options, changing recordkeepers, etc.].

2. As a result of these changes, you temporarily will be unable to [enter as appropriate: direct or diversify investments in your individual accounts (if only specific investments are subject to the blackout), those investments should be specifically identified], obtain a loan from the plan, or obtain a distribution from the plan. This period, during which you will be unable to exercise these rights otherwise available under the plan, is called a “blackout period.” Whether or not you are planning retirement in the near future, we encourage you to carefully consider how this blackout period may affect your retirement planning, as well as your overall financial plan.

3. The blackout period for the plan [enter the following as appropriate: is expected to begin on [enter date] and end [enter date]/is expected to begin during the week of [enter date] and end during the week of [enter date]. During these weeks, you can determine whether the blackout period has started or ended by [enter instructions for use toll-free number or accessing web site].

4. [In the case of investments affected by the blackout period, add the following:] During blackout period you will be unable to direct or diversify the assets held in your plan account. For this reason, it is very important that you review and consider the appropriateness of your current investments in light of your inability to direct or diversify those investments during the blackout period. For your long-term retirement security, you should give careful consideration to the importance of a well-balanced and diversified investment portfolio, taking into account all your assets, income and investments. [If the plan permits investments in individual securities, add the following:] You should be aware that there is a risk to holding substantial portions of your assets in the securities of any one company, as individual securities tend to have wider price swings, up and down, in short periods of time, than investments in diversified funds. Stocks that have wide price swings might have a large loss during the blackout period, and you would not be able to direct the sale of such stocks from your account during the blackout period.

5. [If timely notice cannot be provided (see paragraph (b)(1)(v) of this section) enter:] (A) Federal law generally requires that you be furnished notice of a blackout period at least 30 days in advance of the last date on which you could exercise your affected rights immediately before the commencement of any blackout period in order to provide you with sufficient time to consider the effect of the blackout period on your retirement and financial plans. (B) [Enter explanation of reasons for inability to furnish 30 days advance notice.]

6. If you have any questions concerning this notice, you should contact [enter name, address and telephone number of the plan administrator or other contact responsible for answering questions about the blackout period].

(f) Effective date. This section shall be effective and shall apply to any blackout period commencing on or after January 26, 2003. For the period January 26, 2003 to February 25, 2003, plan administrators shall furnish notice as soon as reasonably possible.

[68 FR 3727, Jan. 24, 2003]

§ 2520.101–4 [Reserved]

§ 2520.101–5 Annual funding notice for defined benefit pension plans.

(a) In general. (1) Except as provided in paragraphs (a)(2) and (3) of this section, pursuant to section 101(f) of the Act, the administrator of a defined benefit plan to which title IV of the Act applies shall furnish annually to each person specified in paragraph (f) of this section a funding notice that conforms to the requirements of this section.

(2) A plan administrator shall not be required to furnish a funding notice— (i) In the case of a multiemployer plan, for a plan year if the due date for such notice is on or after the earlier of: (A) The date the plan complies with the insolvency notice requirements of section 4245(e) or 4281(d)(3) of the Act and regulations thereunder; or (B) The date the plan has distributed assets in satisfaction of all nonforfeitable benefits under the plan pursuant to section 401A of the Act and the regulations thereunder.

(ii) In the case of a single-employer plan, for a plan year if the due date for the funding notice is on or after the date:
(A) The Pension Benefit Guaranty Corporation is appointed as trustee of the plan pursuant to section 4042 of the Act;

(B) The plan has distributed assets in satisfaction of all benefit liabilities in a distress termination pursuant to section 4041(c)(3)(B)(i) of the Act or of all guaranteed benefits in a distress termination pursuant to section 4041(c)(3)(B)(ii) of the Act; or

(C) The plan administrator filed a standard termination notice with the Pension Benefit Guaranty Corporation pursuant to 29 CFR 4041.25, provided that the proposed termination date is on or before the due date of the funding notice and a final distribution of assets in satisfaction of all benefit liabilities proceeds in accordance with section 4041(b) of the Act.

(3) In the case of a merger or consolidation of two or more plans—

(i) The plan administrator of a non-successor plan shall not be required to furnish a funding notice for the plan year in which the merger or consolidation occurred; and

(ii) The funding notice of the successor plan, for the plan year in which the merger or consolidation occurred, must, in addition to the requirements of paragraph (b) of this section, contain a general explanation, including the effective date, of the merger or consolidation and an identification of each plan (e.g., name and plan number) involved in the merger or consolidation.

(b) Content of notice. A funding notice shall include the following information:

(1) Identifying information. The name of the plan, the name, address, and phone number of the plan administrator and the plan’s principal administrative officer (if different than the plan administrator), each plan sponsor’s name and employer identification number, and the plan number.

(2) Funding percentage—(i) Single-employer plans. For single-employer plans, a statement as to whether the plan’s funding target attainment percentage (as defined in section 303(d)(2) of the Act) for the notice year, and for each of the two preceding plan years, is at least 100 percent (and, if not, the actual percentages).

(ii) Multiemployer plans. For multiemployer plans, a statement as to whether the plan’s funded percentage (as defined in section 305(i) of the Act) for the notice year, and for each of the two preceding plan years, is at least 100 percent (and, if not, the actual percentages).

(3) Assets and liabilities—(i) Single-employer plans. For single-employer plans—

(A) A statement of the total assets (separately stating the prefunding balance and the funding standard carryover balance) and liabilities of the plan, determined in the same manner as under section 303 of the Act, as of the valuation date of the notice year and for each of the two preceding plan years, as reported in the annual report filed under section 104 of the Act for each such preceding plan year, and

(B) A statement of the value of the plan’s assets and liabilities determined as of the last day of the notice year. For purposes of this statement, the value of the plan’s assets is the fair market value of plan assets. Plan liabilities are equal to the present value of benefits accrued through the last day of the notice year determined in the same manner as liabilities are calculated under section 303 of the Act (including actuarial assumptions and methods), but using the interest rate under section 4006(a)(3)(E)(iv) of the Act in effect for the last month of the notice year.

(ii) Multiemployer plans. For multiemployer plans—

(A) A statement of the value of the plan’s assets (determined in the same manner as under section 304(c)(2) of the Act) and liabilities (determined in the same manner as under section 305(i)(8) of the Act, using reasonable actuarial assumptions as required under section 304(c)(3) of the Act) as of the valuation date of the notice year and each of the two preceding plan years, and

(B) A statement of the fair market value of plan assets as of the last day of the notice year, and as of the last day of each of the two preceding plan years as reported in the annual report filed under section 104(a) of the Act for each such preceding plan year.

(iii) Contributions receivable. For purposes of determining the fair market
Employee Benefits Security Admin., Labor § 2520.101–5

The value of plan assets as of the last day of the notice year under paragraphs (b)(3)(i)(B) and (b)(3)(ii)(B) of this section, the plan administrator may, but is not required to, include contributions made after the notice year and before the notice is furnished to recipients, but only to the extent such contributions are treated for funding purposes as having been made on account of the notice year under sections 303(g)(4) of the Act, in the case of a single-employer plan, or under section 304(c)(8) of the Act, in the case of a multiemployer plan.

(4) **Demographic information.** A statement of the number of participants and beneficiaries who, as of the valuation date of the notice year, are: Retired or separated from service and receiving benefits; retired or separated from service and entitled to future benefits (but currently not receiving benefits); or active participants under the plan. The statement shall indicate the number of participants and beneficiaries in each category and the sum of all such participants and beneficiaries. The terms “active” and “retired or separated” shall have the same meaning given to those terms in instructions to the annual report filed under section 104(a) of the Act.

(5) **Funding policy.** A statement setting forth—

(i) The funding policy of the plan;
(ii) The asset allocation of investments under the plan (expressed as percentages of total assets) as of the end of the notice year; and
(iii) A general description of any investment policy of the plan as it relates to the funding policy in paragraph (b)(3)(i) of this section and the asset allocation of investments under paragraph (b)(3)(ii) of this section.

(6) **Endangered, critical, or critical and declining status.** In the case of a multiemployer plan, a statement whether the plan was in endangered, critical, or critical and declining status under section 305 of the Act for the notice year and, if so—

(i) A statement describing how a person may obtain a copy of the plan’s funding improvement plan or rehabilitation plan, as appropriate, adopted under section 305 of the Act for the notice year and, if so—

(ii) A summary of the plan’s funding improvement plan or rehabilitation plan, including any update or modification of such funding improvement or rehabilitation plan adopted under section 305 of the Act during the notice year; and
(iii) In the case of a multiemployer plan in critical and declining status:

(A) The projected date of insolvency;
(B) A clear statement that such insolvency may result in benefit reductions; and
(C) A statement describing whether the plan sponsor has taken legally permitted actions to prevent insolvency.

(7) **Events having a material effect on liabilities or assets.** Subject to paragraph (g) of this section, in the case of any plan amendment, scheduled benefit increase or reduction, or other known event taking effect in the current plan year and having a material effect on plan liabilities or assets for the year, an explanation of the amendment, scheduled benefit increase or reduction, or event, and a projection to the end of such plan year of the effect of the amendment, scheduled benefit increase or reduction, or event on plan liabilities.

(8) **Rules on termination or insolvency.**—

(i) **Single-employer plans.** In the case of a single-employer plan, a summary of the rules governing termination of single-employer plans under subtitle C of title IV of the Act.
(ii) **Multiemployer plans.** In the case of a multiemployer plan, a summary of the rules governing insolvency, including the limitations on benefit payments.

(9) **PBGC guarantees.** A general description of the benefits under the plan which are eligible to be guaranteed by the Pension Benefit Guaranty Corporation, along with an explanation of the limitations on the guarantee and the circumstances under which such limitations apply.

(10) **Annual report information.** A statement that a person entitled to notice under paragraph (f) of this section may obtain a copy of the annual report of the plan filed under section 104(a) of the Act upon request through the Internet Web site of the Department of
§2520.101–5

29 CFR Ch. XXV (7–1–15 Edition)

Labor, or through any Intranet Web site maintained by the applicable plan sponsor (or plan administrator on behalf of the plan sponsor).

(11) Information disclosed to PBGC. In the case of a single-employer plan, if applicable, a statement that the contributing sponsor of the plan or a member of the contributing sponsor’s controlled group was required to provide information under section 4010 of the Act for the information year ending in the notice year (see 29 CFR 4010.5).

(12) Additional information. Any additional information that the plan administrator elects to include, provided that such information is necessary or helpful to understanding the mandatory information in the notice, or is otherwise permitted by law.

(c) Style and format of notice. Funding notices shall be written in a manner that is consistent with the style and format requirements of §2520.102–2 of this chapter.

(d) When to furnish notice. (1) Except as provided in paragraph (d)(2) of this section, a funding notice shall be provided not later than 120 days after the end of the notice year.

(2) In the case of a small plan, a funding notice shall be provided not later than the earlier of the date on which the annual report is filed under section 104(a) of the Act or the latest date the annual report must be filed under that section (including extensions). For this purpose, a single-employer plan is a small plan if it meets the exception in section 303(g)(2)(B) of the Act, and a multiemployer plan is a small plan if it had 100 or fewer participants on each day during the plan year preceding the notice year.

(e) Manner of furnishing notice. (1) [Reserved.]

(2) A funding notice must be furnished to the Pension Benefit Guaranty Corporation in a manner consistent with the requirements of part 4000 of title IV of the Act. The date that the notice is furnished to the Pension Benefit Guaranty Corporation is determined consistent with that part.

(f) Persons entitled to notice. Persons entitled to a funding notice under this section are:

(1) Each participant covered under the plan on the last day of the notice year;
(2) Each beneficiary receiving benefits under the plan on the last day of the notice year;
(3) Each alternate payee under the plan on the last day of the notice year;
(4) Each labor organization representing participants under the plan on the last day of the notice year;
(5) In the case of a multiemployer plan, each employer that, as of the last day of the notice year, is a party to the collective bargaining agreement(s) pursuant to which the plan is maintained or who otherwise may be subject to withdrawal liability pursuant to section 4203 of the Act; and

(g) Special rules and definitions for material effect disclosures. (1) The term “current plan year” means the plan year after the notice year. Thus, for example, if the notice year is January 1, 2017 through December 31, 2017, then the current plan year would be January 1, 2018 through December 31, 2018.

(2) An event described in paragraph (b)(7) of this section is recognized as “taking effect” in the current plan year if the effect of the event is taken into account for the first time for funding under section 430 or 431 of the Internal Revenue Code, as applicable, in such year.

(3) An event described in paragraph (b)(7) of this section has a “material effect” if it results, or is projected to result, in an increase or decrease of five percent or more in the value of assets or liabilities from the valuation date of the notice year. For this measurement, calculate assets and liabilities in the same manner as under paragraph (b)(2) of this section.

(4) An event described in paragraph (b)(7) of this section has a “material effect” if, in the judgment of the plan’s enrolled actuary, the effect of the event is considered material for purposes of the plan’s funding status under section 430 or 431, as applicable, of the Internal Revenue Code, without regard to paragraph (g)(3) of this section.

(5) An event described in paragraph (b)(7) of this section is “known” only if it is known by the plan administrator.
prior to 120 days before the due date of the notice. Thus, if an event otherwise described in paragraph (b)(7) first becomes known to a plan administrator 120 days or less before the due date of a notice, the plan administrator is not required to explain, or project the effect of, the event in that notice.

(6) The term “other known event” includes, but is not limited to, an extension of coverage under the existing terms of the plan to a new group of employees; a plan merger, consolidation, or spinoff pursuant to regulations under section 414(l) of the Internal Revenue Code; or, a shutdown of any facility, plant, store, or such other similar corporate event that creates immediate eligibility for benefits that would otherwise be immediately payable for participants separating from service. The term does not include market fluctuations.

(7) With respect to events described in paragraph (g)(4) of this section, the plan administrator may, instead of projecting the effect on plan liabilities to the end of the current plan year, include an explanation why the event is considered material by the enrolled actuary.

(b) Example. The following example illustrates the special rules and definitions of paragraph (g) of this section:

Example. Plan Y is a single-employer calendar year plan. Company X, the sponsor of Plan Y, adopts an amendment on June 1, 2017, offering a subsidized early retirement benefit to participants age 50 or older who retire on or after September 1, 2017 and before March 1, 2018. The amendment increases the liabilities of Plan Y by an amount greater than 5% of the value of Plan Y’s liabilities on January 1, 2017. Company X does not make an election under Code section 412(d)(12) to accelerate recognition of the event for funding. The amendment is taken into account for the first time under section 430 of the Code as of the January 1, 2018 valuation date. Therefore, the amendment is recognized as taking effect under the final rule in 2018. Since the amendment adopted on June 1, 2017, is known more than 120 days prior to the April 30, 2018 due date of the 2017 funding notice, the amendment must be disclosed in the 2017 funding notice under paragraph (b)(7) of the final regulations as a material effect event taking effect in 2018 (i.e., the current plan year).

(h) Model notices. (1) The appendices to this section contain a model notice for single-employer plans and a model notice for multiemployer plans. These models are intended to assist plan administrators in discharging their notice obligations under this section. Use of a model notice is not mandatory. However, subject to paragraph (h)(2) of this section, use of a model notice will be deemed to satisfy the requirements of paragraphs (b)(1) through (b)(11) and paragraph (c) of this section.

(2) To the extent a plan administrator elects to include in a model notice information described in paragraph (b)(12) of this section, such additional information must be consistent with the style and format requirements in paragraph (c) of this section.

(j) Alternative method of compliance for furnishing notice to PBGC for certain single-employer plans. Notwithstanding any other provision of this section, the plan administrator of a single-employer plan is not required to furnish a notice to the Pension Benefit Guaranty Corporation annually if, based on the data described in paragraph (b)(3)(i)(A) of this section for the notice year, plan liabilities do not exceed total plan assets by more than $50 million, provided that the plan administrator furnishes the latest available funding notice to the Pension Benefit Guaranty Corporation within 30 days of a written request.

(k) Alternative method of compliance for multiemployer plans terminated by mass withdrawal. (1) Notwithstanding any other provision of this section, for plan years beginning after the date specified in section 401A(b)(2) of the Act, an alternative method of compliance is available in the case of a multiemployer plan that terminates as a result of the withdrawal of every employer from the plan or the cessation of the obligation of all employers to contribute under the plan, as described in section 401A(a)(2) of the Act. Under this alternative method, the plan administrator shall furnish annually to
each person described in paragraph (f)(1) through (3) of this section a notice that complies with paragraphs (c), (d), (e), and (k)(2) of this section.

(2) The notice includes:
   (i) A statement of the fair market value of the plan’s assets as of the last day of the notice year, and as of the last day of each of the two preceding plan years as reported in the annual report filed under section 104(a) of the Act for each such preceding plan year;
   (ii) A statement of the amount of benefit payments made during the notice year and each of the two preceding plan years;
   (iii) If a notice has not already been furnished pursuant to 29 CFR 4281.32, a statement that benefits may be reduced pursuant to section 4281(c) of the Act and a summary of the rules governing such reductions;
   (iv) A summary of the rules governing insolvency, including the limitations on benefit payments, pursuant to paragraph (b)(8)(ii) of this section;
   (v) The information described in paragraphs (b)(1), (b)(9), and (b)(10) of this section; and
   (vi) Any additional information that the plan administrator elects to include, subject to the requirements of paragraph (b)(12) of this section.

Alternative method of compliance for Internal Revenue Code section 412(e)(3) plans. (1) Notwithstanding any other provision of this section, an alternative method of compliance is available in the case of an insurance contract plan described in section 412(e)(3) of the Internal Revenue Code of 1986. Under this alternative method, the plan administrator shall furnish annually to each person described in paragraph (f) of this section a notice that complies with paragraphs (c), (d), (e), and (l)(2) of this section.

(2) The notice includes:
   (i) An explanation that the plan is funded exclusively by an insurance contract or contracts, that such contract or contracts provide for the benefit payments to participants and beneficiaries, that such benefit payments are guaranteed by a licensed insurance company or companies, and the name of the insurance company or companies;
   (ii) A statement whether, as of the last day of the notice year, there were any delinquent premiums and, if so, the amount and date of the delinquency and the effect on the plan and on participants and beneficiaries in the event of a policy lapse;
   (iii) The information described in paragraph (b)(1), (b)(9), and (b)(10) of this section; and
   (iv) Any additional information that the plan administrator elects to include, provided that such information meets the standard in paragraph (b)(12) of this section.

CSEC plans. [Reserved]

APPENDIX A TO §2520.101–5—SINGLE-EMPLOYER PLAN MODEL ANNUAL FUNDING NOTICE
Behind this cover page is a model notice that may be used to satisfy the mandatory disclosure requirements set forth in 29 CFR 2520.101-5. The model notice is a collection of information instrument subject to the Paperwork Reduction Act. Use of the model notice to meet the disclosure requirements is optional. You may also develop your own notice, provided it contains all of the information required by 29 CFR 2520.101-5. The Department of Labor estimates that it will take an average of approximately 21 hours for plan administrators to complete the model. You may send comments on this collection of information, including suggestions for reducing burden to: US Department of Labor, Policy and Research, Attention: PRA Officer, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210. The disclosure requirements in 29 CFR 2520.101-5, referenced above, are also a collection of information under the PRA. The public is not required to respond to a collection of information unless it displays a currently valid OMB control number.

DO NOT INCLUDE THIS PAPERWORK REDUCTION ACT BANNER IN NOTICES TO PARTICIPANTS AND BENEFICIARIES
ANNUAL FUNDING NOTICE

For

[insert name of single-employer pension plan]

Introduction

This notice includes important information about the funding status of your single-employer pension plan (the “Plan”). It also includes general information about the benefit payments guaranteed by the Pension Benefit Guaranty Corporation (“PBGC”), a federal insurance agency. All traditional pension plans (called “defined benefit pension plans”) must provide this notice every year regardless of their funding status. This notice does not mean that the Plan is terminating. It is provided for informational purposes and you are not required to respond in any way. This notice is required by federal law. This notice is for the plan year beginning [insert beginning date] and ending [insert ending date] (“Plan Year”).

How Well Funded Is Your Plan

The law requires the administrator of the Plan to tell you how well the Plan is funded, using a measure called the “funding target attainment percentage.” The Plan divides its Net Plan Assets by Plan Liabilities to get this percentage. In general, the higher the percentage, the better funded the plan. The Plan’s Funding Target Attainment Percentage for the Plan Year and each of the two preceding plan years is shown in the chart below. The chart also shows you how the percentage was calculated.

<table>
<thead>
<tr>
<th>Funding Target Attainment Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>1. Valuation Date</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>2. Plan Assets</td>
</tr>
<tr>
<td>a. Total Plan Assets</td>
</tr>
<tr>
<td>b. Funding Standard Carryover Balance</td>
</tr>
<tr>
<td>c. Prefunding Balance</td>
</tr>
<tr>
<td>d. Net Plan Assets</td>
</tr>
<tr>
<td>(a) – (b) – (c) = (d)</td>
</tr>
</tbody>
</table>

[insert Plan Year, e.g., 2015]  [insert plan year preceding Plan Year, e.g., 2014]  [insert plan year 2 years preceding Plan year, e.g., 2013]

[insert date]  [insert date]  [insert date]

[insert amount]  [insert amount]  [insert amount]

[insert amount]  [insert amount]  [insert amount]

[insert amount]  [insert amount]  [insert amount]
3. Plan Liabilities [insert amount] [insert amount] [insert amount]

4. At-Risk Liabilities [insert amount] [insert amount] [insert amount]

5. Funding Target Attainment Percentage (2d)/(3) [insert percentage] [insert percentage] [insert percentage]

[Instructions: Report Valuation Date entries in accordance with section 303(g)(2) of ERISA. Report Total Plan Assets in accordance with section 303(g)(3) of ERISA. Report credit balances i.e., funding standard carryover balance and prefunding balance in accordance with section 303(d) of ERISA. Report Net Plan Assets, Plan Liabilities (i.e., funding target), and Funding Target Attainment Percentage in accordance with section 303(d)(2) of ERISA. The amount reported as “Plan Liabilities” should be the funding target determined without regard to at-risk assumptions, even if the plan is in at-risk status. At-Risk Liabilities are determined under section 303(i) of ERISA (taking into account section 303(i)(5) of ERISA). Report At-Risk Liabilities for any year covered by this chart in which the plan was in “at-risk” status within the meaning of section 303(g) of ERISA, only if At-Risk Liabilities are greater than Plan Liabilities; otherwise delete the entire row designated as number 4. Round off all amounts in this chart to the nearest dollar.]

Plan Assets and Credit Balances

The chart above shows certain “credit balances” called the Funding Standard Carryover Balance and Prefunding Balance. A plan might have a credit balance, for example, if in a prior year an employer contributed money to the plan above the minimum level required by law. Generally, an employer may credit the excess money toward the minimum level of contributions required by law that it must make in future years. Plans must subtract these credit balances from Total Plan Assets to calculate their Funding Target Attainment Percentage.

[Instructions: Include the preceding discussion, entitled Plan Assets and Credit Balances, only where such balances exist.]

Plan Liabilities

Plan Liabilities in line 3 of the chart above is an estimate of the amount of assets the Plan needs on the Valuation Date to pay for promised benefits under the Plan.

At-Risk Liabilities

The law considers a plan to be in “at risk” status if its funding target attainment percentage for the prior plan year was below a legal threshold. The sponsor of an at-risk plan must make certain assumptions and contribute more money to that plan. For example, plans in “at-risk” status must assume that all workers eligible to retire in the next 10 years will do so as soon as they can, and that they will take their distribution in whatever form would create the highest cost to the plan, without regard to whether those workers actually do so. The additional contributions that result from “at-risk” status may then remove a plan from this status. The Plan was in “at-risk” status in [enter year or years covered by the chart above]. The At-Risk Liabilities row in the chart above shows the increased liabilities resulting from “at-risk” status.

[Instructions: Include the preceding discussion, entitled At-Risk Liabilities, only in the case of a plan required to report At-Risk Liabilities. Delete the entire row designated as number 4 in the chart above if the At-Risk Liabilities discussion is not included in the notice.]

Year-End Assets and Liabilities

491
The asset values in the chart above are measured as of the first day of the Plan Year. They also are “actuarial values.” Actuarial values differ from market values in that they do not fluctuate daily based on changes in the stock or other markets. Actuarial values smooth out those fluctuations and can allow for more predictable levels of future contributions. Despite the fluctuations, market values tend to show a clearer picture of a plan’s funded status at a given point in time. As of [enter the last day of the Plan Year], the fair market value of the Plan’s assets was [enter amount]. On this same date, the Plan’s liabilities, determined using market rates, were [enter amount].

[Instructions: Insert the fair market value of the plan’s assets as of the last day of the plan year. You may include contributions made after the end of the plan year to which the notice relates and before the date the notice is timely furnished but only if such contributions are attributable to such plan year for funding purposes. A plan’s liabilities as of the last day of the plan year are equal to the present value, as of the last day of the plan year, of benefits accrued as of that same date. With the exception of the interest rate assumption, the present value should be determined using assumptions used to determine the funding target under section 303. The interest rate assumption is the rate provided under section 4006(a)(3)(E)(iv), but using the last month of the year to which the notice relates rather than the month preceding the first month of the year to which the notice relates. If, consistent with section 303(g)(2) of ERISA, the plan’s valuation date is not the first day of the plan year, make appropriate modifications to the preceding paragraph, e.g., replace “first day of” with “valuation date for.”]

[Instructions: If, pursuant to section 303(g)(3) of ERISA, the value of the plan’s assets in the chart above is fair market value, include the paragraph below rather than the paragraph above, but otherwise follow the instructions above.]

The asset values in the chart above are measured as of the first day of the Plan Year. As of [enter the last day of the Plan Year], the fair market value of the Plan’s assets was [enter amount]. On this same date, the Plan’s liabilities, determined using market rates, were [enter amount].

Participant Information

The total number of participants and beneficiaries covered by the Plan on the Valuation Date was [insert number]. Of this number, [insert number] were current employees, [insert number] were retired and receiving benefits, and [insert number] were retired or no longer working for the employer and have a right to future benefits.

Funding & Investment Policies

Every pension plan must have a procedure to establish a funding policy for plan objectives. A funding policy relates to how much money is needed to pay promised benefits. The funding policy of the Plan is [insert a summary statement of the Plan’s funding policy].

Pension plans also have investment policies. These generally are written guidelines or general instructions for making investment management decisions. The investment policy of the Plan is [insert a summary statement of the Plan’s investment policy].

Under the investment policy, the Plan’s assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

[Instructions: Insert and complete either Alternative 1 or Alternative 2, below.]

Alternative 1:
## Employee Benefits Security Admin., Labor  

### § 2520.101–5

<table>
<thead>
<tr>
<th>Asset Allocations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cash (interest bearing and non-interest bearing)</td>
<td></td>
</tr>
<tr>
<td>2. U.S. Government securities</td>
<td></td>
</tr>
<tr>
<td>3. Corporate debt instruments (other than employer securities):</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>All other</td>
<td></td>
</tr>
<tr>
<td>4. Corporate stocks (other than employer securities):</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Common</td>
<td></td>
</tr>
<tr>
<td>5. Partnership/joint venture interests</td>
<td></td>
</tr>
<tr>
<td>6. Real estate (other than employer real property)</td>
<td></td>
</tr>
<tr>
<td>7. Loans (other than to participants)</td>
<td></td>
</tr>
<tr>
<td>8. Participant loans</td>
<td></td>
</tr>
<tr>
<td>9. Value of interest in common/collective trusts</td>
<td></td>
</tr>
<tr>
<td>10. Value of interest in pooled separate accounts</td>
<td></td>
</tr>
<tr>
<td>11. Value of interest in master trust investment accounts</td>
<td></td>
</tr>
<tr>
<td>12. Value of interest in 103-12 investment entities</td>
<td></td>
</tr>
<tr>
<td>13. Value of interest in registered investment companies (e.g., mutual funds)</td>
<td></td>
</tr>
<tr>
<td>14. Value of funds held in insurance co. general account (unallocated contracts)</td>
<td></td>
</tr>
<tr>
<td>15. Employer-related investments:</td>
<td></td>
</tr>
<tr>
<td>Employer Securities</td>
<td></td>
</tr>
<tr>
<td>Employer real property</td>
<td></td>
</tr>
<tr>
<td>16. Buildings and other property used in plan operation</td>
<td></td>
</tr>
<tr>
<td>17. Other</td>
<td></td>
</tr>
</tbody>
</table>

For information about the Plan’s investment in any of the following types of investments – common/collective trusts, pooled separate accounts, master trust investment accounts, or 103-12 investment entities – contact [insert the name, telephone number, email address or mailing address of the plan administrator or designated representative].

[Instructions: Percentages must total 100%. If a plan holds an interest in one or more of the direct filing entities (DFEs) noted above, i.e., MIAAs, CCEs, PSAs, or 103-12Es and the administrator does not break out the DFE’s investments among the other asset classes, immediately following the asset allocation chart include the paragraph above informing recipients how to obtain more information regarding the plan’s DFE investments (e.g., the plan’s Schedule D and/or the DFE’s Schedule H). If a plan does not hold an interest in a DFE or the plan administrator breaks out the investments of all DFEs among the other asset classes, do not include the above paragraph. If the administrator knows the actual asset allocation of an MTA, the MTA entry (line 11) should not be competed and the investments of the MTA should be reflected in the relevant asset classes.]

### Alternative 2

<table>
<thead>
<tr>
<th>Asset Allocations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stocks</td>
<td></td>
</tr>
<tr>
<td>Investment grade debt instruments</td>
<td></td>
</tr>
<tr>
<td>High-yield debt instruments</td>
<td></td>
</tr>
<tr>
<td>Real estate</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

[Instructions: Percentages must total 100%. Follow the instructions for the latest Schedule R to Form 5500 to allocate investments to one of the above asset classes.]

**Events Having a Material Effect on Assets or Liabilities**

493
§ 2520.101–5

By law this notice must contain a written explanation of new events that have a material effect on plan liabilities or assets. This is because such events can significantly impact the funding condition of a plan. For the plan year beginning on [insert the first day of the current plan year (i.e., the year after the notice year)] and ending on [insert the last day of the current plan year], the Plan expects the following events to have such an effect: [Insert explanation of any plan amendment, scheduled benefit increase or reduction, or other known event taking effect in the current plan year and having a material effect on plan liabilities or assets for the current plan year, as well as a projection to the end of the current plan or the effect of the amendment, scheduled increase or reduction, or event on plan liabilities].

[Instructions: Include the preceding discussion, entitled Events having a Material Effect on Assets or Liabilities, only if and to the extent applicable.]

Right to Request a Copy of the Annual Report

Pension plans must file annual reports with the US Department of Labor. The report is called the “Form 5500.” These reports contain financial and other information. You may obtain an electronic copy of your Plan’s annual report by going to www.efast.dol.gov and using the search tool. Annual reports also are available from the US Department of Labor, Employee Benefits Security Administration’s Public Disclosure Room at 200 Constitution Avenue, NW, Room N-1513, Washington, DC 20210, or by calling 202.693.8673. Or you may obtain a copy of the Plan’s annual report by making a written request to the plan administrator. [If the Plan’s annual report is available on an Intranet website maintained by the plan sponsor (or plan administrator on behalf of the plan sponsor), modify the preceding sentence to include a statement that the annual report also may be obtained through that website and include the website address.] Annual reports do not contain personal information, such as the amount of your accrued benefits. You may contact your plan administrator if you want information about your accrued benefits. Your plan administrator is identified below under “Where To Get More Information.”

Summary of Rules Governing Termination of Single-Employer Plans

If a plan terminates, there are specific termination rules that must be followed under federal law. A summary of these rules follows.

There are two ways an employer can terminate its pension plan. First, the employer can end a plan in a “standard termination” but only after showing the PBGC that such plan has enough money to pay all benefits owed to participants. Under a standard termination, a plan must either purchase an annuity from an insurance company (which will provide you with periodic retirement benefits, such as monthly for life or for a set period of time when you retire) or, if the plan allows, issue one lump-sum payment that covers your entire benefit. Your plan administrator must give you advance notice that identifies the insurance company (or companies) selected to provide the annuity. The PBGC’s guarantee ends upon the purchase of an annuity or payment of the lump-sum. If the plan purchases an annuity for you from an insurance company and that company becomes unable to pay, the applicable state guaranty association guarantees the annuity to the extent authorized by that state’s law.
Employee Benefits Security Admin., Labor § 2520.101–5

Second, if the plan is not fully-funded, the employer may apply for a distress termination. To do so, however, the employer must be in financial distress and prove to a bankruptcy court or to the PBGC that the employer cannot remain in business unless the plan is terminated. If the application is granted, the PBGC will take over the plan as trustee and pay plan benefits, up to the legal limits, using plan assets and PBGC guarantee funds.

Under certain circumstances, the PBGC may take action on its own to end a pension plan. Most terminations initiated by the PBGC occur when the PBGC determines that plan termination is needed to protect the interests of plan participants or of the PBGC insurance program. The PBGC can do so if, for example, a plan does not have enough money to pay benefits currently due.

Benefit Payments Guaranteed by the PBGC

When the PBGC takes over a plan, it pays pension benefits through its insurance program. Only benefits that you have earned a right to receive and that cannot be forfeited (called vested benefits) are guaranteed. Most participants and beneficiaries receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits that are not guaranteed.

The amount of benefits that PBGC guarantees is determined as of the plan termination date. However, if a plan terminates during a plan sponsor’s bankruptcy, then the amount guaranteed is determined as of the date the sponsor entered bankruptcy.

The PBGC maximum benefit guarantee is set by law and is updated each calendar year. For a plan with a termination date or sponsor bankruptcy date, as applicable in [insert current calendar year], the maximum guarantee is [insert amount from PBGC web site, www.pbgc.gov, applicable for the current calendar year] per month, or [insert amount from PBGC web site, www.pbgc.gov, applicable for the current calendar year] per year, for a benefit paid to a 65-year-old retiree with no survivor benefit. If a plan terminates during a plan sponsor’s bankruptcy, the maximum guarantee is fixed as of the calendar year in which the sponsor entered bankruptcy. The maximum guarantee is lower for an individual who begins receiving benefits from PBGC before age 65 reflecting the fact that younger retirees are expected to receive more monthly pension checks over their lifetimes. [If the plan does not provide for commencement of benefits before age 65, you may omit this sentence.] Similarly, the maximum guarantee is higher for an individual who starts receiving benefits from PBGC after age 65. The maximum guarantee by age can be found on PBGC’s website, www.pbgc.gov. The guaranteed amount is also reduced if a benefit will be provided to a survivor of the plan participant.

The PBGC guarantees “basic benefits” earned before a plan is terminated, which include [Include the following guarantees that apply to benefits available under the plan.]:

- pension benefits at normal retirement age;
- most early retirement benefits;
- annuity benefits for survivors of plan participants; and
- disability benefits for a disability that occurred before the date the plan terminated or the date the sponsor entered bankruptcy, as applicable.
§ 2520.101–5 29 CFR Ch. XXV (7–1–15 Edition)

The PBGC does not guarantee certain types of benefits [Include the following guarantee limits that apply to the benefits available under the plan.]:

- The PBGC does not guarantee benefits for which you do not have a vested right, usually because you have not worked enough years for the company.

- The PBGC does not guarantee benefits for which you have not met all age, service, or other requirements.

- Benefit increases and new benefits that have been in place for less than one year are not guaranteed. Those that have been in place for less than five years are only partly guaranteed.

- Early retirement payments that are greater than payments at normal retirement age may not be guaranteed. For example, a supplemental benefit that stops when you become eligible for Social Security may not be guaranteed.

- Benefits other than pension benefits, such as health insurance, life insurance, death benefits, vacation pay, or severance pay, are not guaranteed.

- The PBGC generally does not pay lump sums exceeding $5,000.

In some circumstances, participants and beneficiaries still may receive some benefits that are not guaranteed. This depends on how much money the terminated plan has and how much the PBGC recovers from employers for plan underfunding.

For additional general information about the PBGC and the pension insurance program guarantees, go to the “General FAQs about PBGC” on PBGC’s website at www.pbgc.gov/generalfaqs. Please contact your employer or plan administrator for specific information about your pension plan or pension benefit. PBGC does not have that information. See “Where to Get More Information About Your Plan,” below.

Corporate and Actuarial Information on File with PBGC

A plan sponsor must provide the PBGC with financial information about itself and actuarial information about the plan under certain circumstances, such as when the funding target attainment percentage of the plan (or any other pension plan sponsored by a member of the sponsor’s controlled group) falls below 80 percent (other triggers may also apply). The sponsor of the Plan, [enter name of plan sponsor] or a member of its controlled group, was subject to this requirement to provide corporate financial information and plan actuarial information to the PBGC. The PBGC uses this information for monitoring and other purposes.

[Instructions: Insert the preceding paragraph entitled “Corporate and Actuarial Information on File with PBGC” only if a reporting under section 4010 of ERISA was required for the information year ending in the Plan Year. Modify the preceding paragraph, as appropriate, if the plan sponsor is the sole member of its controlled group.

Where to Get More Information

For more information about this notice, you may contact [enter name of plan administrator and if applicable, principal administrative officer], at [enter phone number and address and insert email address if appropriate]. For identification purposes, the official plan number is [enter plan number] and the plan sponsor’s name and employer identification number or “EIN” are [enter name and EIN of plan sponsor].
Employee Benefits Security Admin., Labor § 2520.101–5

APPENDIX B TO § 2520.101–5—MULTIEMPLOYER PLAN MODEL ANNUAL FUNDING NOTICE

PAPERWORK BURDEN DISCLOSURE NOTICE
OMB Control Number 1210-0126; expires 04/17/2017

Behind this cover page is a model notice that may be used to satisfy the mandatory disclosure requirements set forth in 29 CFR 2520.101-5. The model notice is a collection of information instrument subject to the Paperwork Reduction Act. Use of the model notice to meet the disclosure requirements is optional. You may also develop your own notice, provided it contains all of the information required by 29 CFR 2520.101-5. The Department of Labor estimates that it will take an average of approximately 21 hours for plan administrators to complete the model. You may send comments on this collection of information, including suggestions for reducing burden to: US Department of Labor, Policy and Research, Attention: PRA Officer, 200 Constitution Avenue, NW, Room N-5718, Washington, DC 20210. The disclosure requirements in 29 CFR 2520.101-5, referenced above, are also a collection of information under the PRA. The public is not required to respond to a collection of information unless it displays a currently valid OMB control number.

DO NOT INCLUDE THIS PAPERWORK REDUCTION ACT BANNER IN NOTICES TO PARTICIPANTS AND BENEFICIARIES
ANNUAL FUNDING NOTICE

For
[insert name of multiemployer pension plan]

Introduction

This notice includes important information about the funding status of your multiemployer pension plan (the “Plan”). It also includes general information about the benefit payments guaranteed by the Pension Benefit Guaranty Corporation (“PBGC”), a federal insurance agency. All traditional pension plans (called “defined benefit pension plans”) must provide this notice every year regardless of their funding status. This notice does not mean that the Plan is terminating. It is provided for informational purposes and you are not required to respond in any way. This notice is required by federal law. This notice is for the plan year beginning [insert beginning date] and ending [insert ending date] (“Plan Year”).

How Well Funded Is Your Plan

The law requires the administrator of the Plan to tell you how well the Plan is funded, using a measure called the “funded percentage.” The Plan divides its assets by its liabilities on the Valuation Date for the plan year to get this percentage. In general, the higher the percentage, the better funded the plan. The Plan’s funded percentage for the Plan Year and each of the two preceding plan years is shown in the chart below. The chart also states the value of the Plan’s assets and liabilities for the same period.

<table>
<thead>
<tr>
<th>Funded Percentage</th>
<th>[insert Plan Year, e.g., 2015]</th>
<th>[insert plan year preceding Plan Year, e.g., 2014]</th>
<th>[insert plan year 2 years preceding Plan Year, e.g., 2013]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valuation Date</td>
<td>[insert date]</td>
<td>[insert date]</td>
<td>[insert date]</td>
</tr>
<tr>
<td>Funded Percentage</td>
<td>[insert percentage]</td>
<td>[insert percentage]</td>
<td>[insert percentage]</td>
</tr>
</tbody>
</table>
Employee Benefits Security Admin., Labor § 2520.101–5

<table>
<thead>
<tr>
<th>Value of Assets</th>
<th>[insert amount]</th>
<th>[insert amount]</th>
<th>[insert amount]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value of Liabilities</td>
<td>[insert amount]</td>
<td>[insert amount]</td>
<td>[insert amount]</td>
</tr>
</tbody>
</table>

[Instructions: The plan’s “funded percentage” is equal to a fraction, the numerator of which is the actuarial value of the plan’s assets (determined in the same manner as under section 304(c)(2) of ERISA) and the denominator of which is the accrued liability of the plan (under section 305(i)(8) of ERISA, using reasonable actuarial assumptions as required under section 304(c)(3) of ERISA). Report the value of the plan’s assets and liabilities in the same manner as under section 304 of ERISA (but determining the plan’s liabilities under section 305(i)(8) of ERISA, using reasonable actuarial assumptions as required under section 304(c)(3) of ERISA) as of the plan’s valuation date for the plan year. Round off all amounts in this chart to the nearest dollar.]

Year-End Fair Market Value of Assets

The asset values in the chart above are measured as of the Valuation Date. They also are “actuarial values.” Actuarial values differ from market values in that they do not fluctuate daily based on changes in the stock or other markets. Actuarial values smooth out those fluctuations and can allow for more predictable levels of future contributions. Despite the fluctuations, market values tend to show a clearer picture of a plan’s funded status at a given point in time. The asset values in the chart below are market values and are measured on the last day of the Plan Year. The chart also includes the year-end market value of the Plan’s assets for each of the two preceding plan years.

<table>
<thead>
<tr>
<th>Fair Market Value of Assets</th>
<th>[insert last day of Plan Year, e.g., 2015]</th>
<th>[insert last day of plan year preceding Plan Year, e.g., 2014]</th>
<th>[insert last day of plan year 2 years preceding Plan Year, e.g., 2013]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[insert amount]</td>
<td>[insert amount]</td>
<td>[insert amount]</td>
</tr>
</tbody>
</table>

[Instructions: Insert the fair market value of the plan’s assets as of the last day of the plan year. You may include contributions made after the end of the plan year to which the notice relates and before the date the notice is timely furnished but only if such contributions are attributable to each plan year for funding purposes. For each of the two preceding plan years, you may use the fair market value of assets on the last day of the plan year as reported in the annual report for such plan year.]

Endangered, Critical, or Critical and Declining Status

Under federal pension law, a plan generally is in “endangered” status if its funded percentage is less than 80 percent. A plan is in “critical” status if the funded percentage is less than 65 percent (other factors may also apply). A plan is in “critical and declining” status if it is in critical status and is projected to become insolvent (run out of money to pay benefits) within 15 years (or within 20 years if a special rule applies). If a pension plan enters endangered status, the trustees of the plan are required to adopt a funding improvement plan. Similarly, if a pension plan enters critical status or critical and declining status, the trustees of the plan are required to adopt a rehabilitation plan. Funding improvement and rehabilitation plans establish steps and benchmarks for pension plans to improve their funding status over a
§ 2520.101–5 29 CFR Ch. XXV (7–1–15 Edition)

specified period of time. The plan sponsor of a plan in critical and declining status may apply for approval to amend the plan to reduce current and future payment obligations to participants and beneficiaries.

Instructions: Select and complete the appropriate option below.

[Option one]
The Plan was not in endangered, critical, or critical and declining status in the Plan Year.

[Option two]
The Plan was in [insert “endangered” or “critical”] status in the Plan Year ending [insert last day of Plan Year] because [insert summary description of why plan was in this status based on statutory factors]. In an effort to improve the Plan’s funding situation, the trustees adopted [insert summary of the plan’s funding improvement or rehabilitation plan, including when adopted and expected duration, and a description of any modification or update to the plan adopted during the plan year to which the notice relates]. You may get a copy of the Plan’s [insert “funding improvement plan” or “rehabilitation plan”], any update to such plan and the actuarial and financial data that demonstrate any action taken by the Plan toward fiscal improvement. You may get this information by contacting the plan administrator. [If applicable, insert: “Or you may obtain this information at [insert Intranet address of plan sponsor (or plan administrator on behalf of the plan sponsor)].”]

[Option three]
The Plan was in critical and declining status in the Plan Year ending [insert last day of Plan Year] because [insert summary description of why plan was in this status based on statutory factors]. The Plan is projected to be insolvent in the [insert plan year] Plan Year. Such insolvency may result in benefit reductions. In an effort to improve the Plan’s funding situation, the trustees adopted a rehabilitation plan on [insert date]. The rehabilitation plan [Insert a summary of the plan’s rehabilitation plan, including expected duration and a description of any modification or update to the plan adopted during the plan year to which the notice relates]. [Insert the following if applicable: The plan sponsor has taken the following legally permitted actions to prevent insolvency: [Insert explanation of actions].” You may get a copy of the Plan’s rehabilitation plan, any update to such plan and the actuarial and financial data that demonstrate any action taken by the Plan toward fiscal improvement. You may get this information by contacting the plan administrator. [If applicable, insert: “Or you may obtain this information at [insert Intranet address of plan sponsor (or plan administrator on behalf of the plan sponsor)].”]

If the Plan is in endangered, critical, or critical and declining status for the plan year ending [insert the last day of the plan year following the Plan Year], separate notification of that status has or will be provided.

Participant Information

The total number of participants and beneficiaries covered by the Plan on the valuation date was [insert number]. Of this number, [insert number] were current employees, [insert number] were retired and receiving benefits, and [insert number] were retired or no longer working for the employer and have a right to future benefits.
Every pension plan must have a procedure to establish a funding policy for plan objectives. A funding policy relates to how much money is needed to pay promised benefits. The funding policy of the Plan is [insert a summary statement of the Plan’s funding policy].

Pension plans also have investment policies. These generally are written guidelines or general instructions for making investment management decisions. The investment policy of the Plan is [insert a summary statement of the Plan’s investment policy].

Under the Plan’s investment policy, the Plan’s assets were allocated among the following categories of investments, as of the end of the Plan Year. These allocations are percentages of total assets:

[Instructions: Insert and complete either Alternative 1 or Alternative 2, below.]

**Alternative 1:**

<table>
<thead>
<tr>
<th>Asset Allocations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cash (Interest bearing and non-interest bearing)</td>
<td></td>
</tr>
<tr>
<td>2. U.S. Government securities</td>
<td></td>
</tr>
<tr>
<td>3. Corporate debt instruments (other than employer securities):</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>All other</td>
<td></td>
</tr>
<tr>
<td>4. Corporate stocks (other than employer securities):</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
</tr>
<tr>
<td>Common</td>
<td></td>
</tr>
<tr>
<td>5. Partnership/joint venture interests</td>
<td></td>
</tr>
<tr>
<td>6. Real estate (other than employer real property)</td>
<td></td>
</tr>
<tr>
<td>7. Loans (other than to participants)</td>
<td></td>
</tr>
<tr>
<td>8. Participant loans</td>
<td></td>
</tr>
<tr>
<td>9. Value of interest in common/collective trusts</td>
<td></td>
</tr>
<tr>
<td>10. Value of interest in pooled separate accounts</td>
<td></td>
</tr>
<tr>
<td>11. Value of interest in 103-12 investment entities</td>
<td></td>
</tr>
<tr>
<td>12. Value of interest in registered investment companies (e.g., mutual funds)</td>
<td></td>
</tr>
<tr>
<td>13. Value of funds held in insurance co. general account (unallocated contracts)</td>
<td></td>
</tr>
<tr>
<td>14. Employer-related investments:</td>
<td></td>
</tr>
<tr>
<td>Employer Securities</td>
<td></td>
</tr>
<tr>
<td>Employer real property</td>
<td></td>
</tr>
<tr>
<td>15. Buildings and other property used in plan operation</td>
<td></td>
</tr>
<tr>
<td>16. Other</td>
<td></td>
</tr>
</tbody>
</table>

For information about the Plan’s investment in any of the following types of investments—common/collective trusts, pooled separate accounts, or 103-12 investment entities – contact [insert the name, telephone number, email address or mailing address of the plan administrator or designated representative].
§ 2520.101–5  

Alternative 2

<table>
<thead>
<tr>
<th>Asset Allocations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stocks</td>
<td></td>
</tr>
<tr>
<td>Investment grade debt instruments</td>
<td></td>
</tr>
<tr>
<td>High-yield debt instruments</td>
<td></td>
</tr>
<tr>
<td>Real estate</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Events Having a Material Effect on Assets or Liabilities

By law this notice must contain a written explanation of new events that have a material effect on plan liabilities or assets. This is because such events can significantly impact the funding condition of a plan. For the plan year beginning on [insert the first day of the current plan year (i.e., the year after the notice year)] and ending on [insert the last day of the current plan year], the Plan expects the following events to have such an effect: [Insert explanation of any plan amendment, scheduled benefit increase or reduction, or other known event taking effect in the current plan year and having a material effect on plan liabilities or assets for the current plan year, as well as a projection to the end of the current plan of the effect of the amendment, scheduled increase or reduction, or event on plan liabilities].

Right to Request a Copy of the Annual Report

Pension plans must file annual reports with the US Department of Labor. The report is called the “Form 5500.” These reports contain financial and other information. You may obtain an electronic copy of your Plan’s annual report by going to www.efast.dol.gov and using the search tool. Annual reports also are available from the US Department of Labor, Employee Benefits Security Administration’s Public Disclosure Room at 200 Constitution Avenue, NW, Room N-1513, Washington, DC 20210, or by calling 202.693.8673. Or you may obtain a copy of the Plan’s annual report by making a written request to the plan administrator. [If the plan’s annual report is available on an Intranet website maintained by the plan sponsor (or plan administrator on behalf of the plan sponsor), modify the preceding sentence to include a statement that the annual report also may be obtained through that website and include the website address.] Annual reports do not contain personal information, such as the amount of your accrued benefit. You may contact your plan
Employee Benefits Security Admin., Labor § 2520.101–5

§ 2520.101–5

administrator if you want information about your accrued benefits. Your plan administrator is identified below under “Where To Get More Information.”

Summary of Rules Governing Insolvent Plans

Federal law has a number of special rules that apply to financially troubled multiemployer plans that become insolvent, either as ongoing plans or plans terminated by mass withdrawal. The plan administrator is required by law to include a summary of these rules in the annual funding notice. A plan is insolvent for a plan year if its available financial resources are not sufficient to pay benefits when due for that plan year. An insolvent plan must reduce benefit payments to the highest level that can be paid from the plan’s available resources. If such resources are not enough to pay benefits at the level specified by law (see Benefit Payments Guaranteed by the PBGC, below), the plan must apply to the PBGC for financial assistance. The PBGC will loan the plan the amount necessary to pay benefits at the guaranteed level. Reduced benefits may be restored if the plan’s financial condition improves.

A plan that becomes insolvent must provide prompt notice of its status to participants and beneficiaries, contributing employers, labor unions representing participants, and PBGC. In addition, participants and beneficiaries also must receive information regarding whether, and how, their benefits will be reduced or affected, including loss of a lump sum option.

Benefit Payments Guaranteed by the PBGC

The maximum benefit that the PBGC guarantees is set by law. Only benefits that you have earned a right to receive and that cannot be forfeited (called vested benefits) are guaranteed. There are separate insurance programs with different benefit guarantees and other provisions for single-employer plans and multiemployer plans. Your Plan is covered by PBGC’s multiemployer program. Specifically, the PBGC guarantees a monthly benefit payment equal to 100 percent of the first $11 of the Plan’s monthly benefit accrual rate, plus 75 percent of the next $33 of the accrual rate, times each year of credited service. The PBGC’s maximum guarantee, therefore, is $35.75 per month times a participant’s years of credited service.

Example 1: If a participant with 10 years of credited service has an accrued monthly benefit of $60, the accrual rate for purposes of determining the PBGC guarantee would be determined by dividing the monthly benefit by the participant’s years of service ($600/10), which equals $60. The guaranteed amount for a $60 monthly accrual rate is equal to the sum of $11 plus $24.75 (.75 x $33), or $35.75. Thus, the participant’s guaranteed monthly benefit is $357.50 ($35.75 x 10).

Example 2: If the participant in Example 1 has an accrued monthly benefit of $200, the accrual rate for purposes of determining the guarantee would be $20 (or $200/10). The guaranteed amount for a $20 monthly accrual rate is equal to the sum of $11 plus $6.75 (.75 x $9), or $17.75. Thus, the participant’s guaranteed monthly benefit would be $177.50 ($17.75 x 10).

The PBGC guarantees pension benefits payable at normal retirement age and some early retirement benefits. In addition, the PBGC guarantees qualified preretirement survivor benefits (which are preretirement death benefits payable to the surviving spouse of a participant who dies before starting to receive benefit payments). In calculating a person’s monthly payment,
§ 2520.101–6 Multiemployer pension plan information made available on request.

(a) In general. For purposes of compliance with the requirements of section 101(k) of the Employee Retirement Income Security Act of 1974, as amended (the Act), 29 U.S.C. 1001, et seq., the administrator of a multiemployer pension plan shall, in accordance with the requirements of this section, furnish copies of reports and applications described in paragraph (c) of this section to plan participants, beneficiaries, employee representatives and contributing employers, described in paragraph (e) of this section.

(b) Obligation to furnish. (1) Except as provided in paragraph (d) of this section, the administrator of a multiemployer pension plan shall, not later than 30 days after receipt of a written request for a report(s) or application(s) described in paragraph (c) of this section from a plan participant, beneficiary, employee representative or contributing employer described in paragraph (e) of this section, furnish the requested document or documents to the requester.

(2) The plan administrator shall furnish reports and applications pursuant to paragraph (b)(1) of this section in a manner consistent with the requirements of 29 CFR 2520.104b–1, including paragraph (c) of that section relating to the use of electronic media.

(3) The plan administrator may impose a reasonable charge to cover the costs of furnishing documents pursuant to this section, but in no event may such charge exceed—

(i) The lesser of: (A) The actual cost to the plan for the least expensive means of acceptable reproduction of the document(s) or (B) 25 cents per page; plus

(ii) The cost of mailing or delivery of the document.

(c) Documents to be furnished. For purposes of paragraph (a) of this section, and subject to paragraph (d) of this section, a plan participant, beneficiary, employee representative or contributing employer described in paragraph (e) of this section, shall be entitled to request and receive a copy of any:

(1) Periodic actuarial report. For this purpose the term “periodic actuarial report” means any—

(i) Actuarial report prepared by an actuary of the plan and received by the plan at regularly scheduled, recurring intervals; and

(ii) Study, test (including a sensitivity test), document, analysis or...
other information (whether or not called a “report”) received by the plan from an actuary of the plan that depicts alternative funding scenarios based on a range of alternative actuarial assumptions, whether or not such information is received by the plan at regularly scheduled, recurring intervals.

(2) Quarterly, semi-annual, or annual financial report prepared for the plan by any plan investment manager or advisor (without regard to whether such advisor is a fiduciary within the meaning of section 3(21) of the Act) or other fiduciary; and

(3) Application filed with the Secretary of the Treasury requesting an extension under section 304 of the Act or section 431(d) of the Internal Revenue Code of 1986 and the determination of such Secretary pursuant to such application.

(d) Limitations and exceptions. For purposes of this section, reports and applications (and related determinations) required to be disclosed under this section shall not include:

(1) Any report or application that was furnished to the requester within the 12-month period immediately preceding the date on which the request is received by the plan;

(2) Any report or application that, as of the date on which the request is received by the plan, has been in the plan’s possession for 6 years or more;

(3) Any report described in paragraph (c)(1) and (c)(2) of this section that, as of the date on which the request is received by the plan, has not been in the plan’s possession for at least 30 days; except that, if the plan administrator elects not to furnish any such document, the administrator shall furnish a notice, not later than 30 days after the date on which request is received by the plan, informing the requester of the existence of the document and the earliest date on which the document can be furnished by the plan.

(4) Any information or data which served as the basis for any report or application described in paragraph (c) of this section, although nothing herein shall limit any other right that a person may have to review or obtain such information under the Act; or

(5)(i) Any information within a report or application that the plan administrator reasonably determines to be either:

(A) Individually identifiable information with respect to any plan participant, beneficiary, employee, fiduciary, or contributing employer, except that such limitation shall not apply to an investment manager, adviser, or other person (other than an employee of the plan) preparing a financial report described in paragraph (c)(2) of this section; or

(B) Proprietary information regarding the plan, any contributing employer, or entity providing services to the plan.

(ii) For purposes of paragraph (d)(5)(i)(B) of this section, the term “proprietary information” means trade secrets and other non-public information (e.g., processes, procedures, formulas, methodologies, techniques, strategies) that, if disclosed by the plan, may cause, or increase a reasonable risk of, financial harm to the plan, a contributing employer, or entity providing services to the plan.

(iii) The plan administrator may treat information relating to a contributing employer or entity providing services to the plan as other than proprietary if the contributing employer or service provider has not identified such information as proprietary.

(iv) A plan administrator shall inform the requester if the plan administrator withholds any information described in paragraph (d)(5)(i) of this section from a report or application requested under paragraph (b) of this section.

(e) Persons entitled to request documents. For purposes of this section, a plan participant, beneficiary, employee representative or contributing employer entitled to request and receive reports and applications includes:

(1) Any participant within the meaning of section 3(7) of the Act;

(2) Any beneficiary receiving benefits under the plan;

(3) Any labor organization representing participants under the plan;

(4) Any employer that is a party to the collective bargaining agreement(s) pursuant to which the plan is maintained or who otherwise may be subject
to withdrawal liability pursuant to section 4203 of the Act.

[75 FR 9341, Mar. 2, 2010]

Subpart B—Contents of Plan Descriptions and Summary Plan Descriptions

§ 2520.102–1 [Reserved]

§ 2520.102–2 Style and format of summary plan description.

(a) Method of presentation. The summary plan description shall be written in a manner calculated to be understood by the average plan participant and shall be sufficiently comprehensive to apprise the plan’s participants and beneficiaries of their rights and obligations under the plan. In fulfilling these requirements, the plan administrator shall exercise considered judgment and discretion by taking into account such factors as the level of comprehension and education of typical participants in the plan and the complexity of the terms of the plan. Consideration of these factors will usually require the limitation or elimination of technical jargon and of long, complex sentences, the use of clarifying examples and illustrations, the use of clear cross references and a table of contents.

(b) General format. The format of the summary plan description must not have the effect to misleading, misinforming or failing to inform participants and beneficiaries. Any description of exception, limitations, reductions, and other restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall not be minimized, rendered obscure or otherwise made to appear unimportant. Such exceptions, limitations, reductions, or restrictions of plan benefits shall be described or summarized in a manner not less prominent than the style, captions, printing type, and prominence used to describe or summarize plan benefits. The advantages and disadvantages of the plan shall be presented without either exaggerating the benefits or minimizing the limitations. The description or summary of restrictive plan provisions need not be disclosed in the summary plan description in close conjunction with the description or summary of benefits, provided that adjacent to the benefit description the page on which the restrictions are described is noted.

(c) Foreign languages. In the case of either—

(1) A plan that covers fewer than 100 participants at the beginning of a plan year, and in which 25 percent or more of all plan participants are literate only in the same non-English language, or

(2) A plan which covers 100 or more participants at the beginning of the plan year, and in which the lesser of (i) 500 or more participants, or (ii) 10% or more of all plan participants are literate only in the same non-English language, so that a summary plan description in English would fail to inform these participants adequately of their rights and obligations under the plan, the plan administrator for such plan shall provide these participants with an English-language summary plan description which prominently displays a notice, in the non-English language common to these participants, offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan. The notice offering assistance contained in the summary plan description shall clearly set forth in the non-English language common to such participants offering them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan.

Example. Employer A maintains a pension plan which covers 1000 participants. At the beginning of a plan year five hundred of Employer A’s covered employees are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining 399 are literate in...
English. Each of the 1000 employees receives a summary plan description in English, containing an assistance notice in both Spanish and Vietnamese stating the following:

"This booklet contains a summary in English of your plan rights and benefits under Employer A Pension Plan. If you have difficulty understanding any part of this booklet, contact Mr. John Doe, the plan administrator, at his office in Room 123, 456 Main St., Anywhere City, State 20001. Office hours are from 8:30 A.M. to 5:00 P.M. Monday through Friday. You may also call the plan administrator's office at (202) 555-2345 for assistance."

[42 FR 37180, July 19, 1977]

§ 2520.102–3 Contents of summary plan description.

Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of the date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

(a) The name of the plan, and, if different, the name by which the plan is commonly known by its participants and beneficiaries;

(b) The name and address of—

(1) In the case of a single employer plan, the employer whose employees are covered by the plan,

(2) In the case of a plan maintained by an employee organization for its members, the employee organization that maintains the plan,

(3) In the case of a collectively-bargained plan established or maintained by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, parent or most significantly employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b–1 and 2520.104b–30; or

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

(4) In the case of a plan established or maintained by two or more employers, the association, committee, joint board of trustees, parent or most significant employer of a group of employers all of which contribute to the same plan, or other similar representative of the parties who established or maintain the plan, as well as

(i) A statement that a complete list of the employers sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b–1 and 2520.104b–30, or

(ii) A statement that participants and beneficiaries may receive from the plan administrator, upon written request, information as to whether a particular employer is a sponsor of the plan and, if the employer is a plan sponsor, the sponsor's address.

(c) The employer identification number (EIN) assigned by the Internal Revenue Service to the plan sponsor and the plan number assigned by the plan sponsor. (For further detailed explanation, see the instructions to the plan description Form EBS–1 and "Identification Numbers Under ERISA" (Publ. 1004), published jointly by DOL, IRS, and PBGC);

(d) The type of pension or welfare plan, e.g. pension plans—defined benefit, defined contribution, 401(k), cash balance, money purchase, profit sharing, ERISA section 404(c) plan, etc., and for welfare plans—group health plans, disability, pre-paid legal services, etc.

(e) The type of administration of the plan, e.g., contract administration, insurer administration, etc.;

(f) The name, business address and business telephone number of the plan administrator, and is available for examination by participants and beneficiaries, as required by §§ 2520.104b–1 and 2520.104b–30; or
§ 2520.102–3 29 CFR Ch. XXV (7–1–15 Edition)

administrator as that term is defined by section 3(16) of the Act;

(g) The name of the person designated as agent for service of legal process, and the address at which process may be served on such person, and in addition, a statement that service of legal process may be made upon a plan trustee or the plan administrator;

(h) The name, title and address of the principal place of business of each trustee of the plan;

(i) If a plan is maintained pursuant to one or more collective bargaining agreements, a statement that the plan is so maintained, and that a copy of any such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§2520.104b–1 and 2520.104b–30. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes;

(j) The plan’s requirements respecting eligibility for participation and for benefits. The summary plan description shall describe the plan’s provisions relating to eligibility to participate in the plan and the information identified in paragraphs (j)(1), (2) and (3) of this section, as appropriate.

(1) For employee pension benefit plans, it shall also include a statement describing the plan’s normal retirement age, as that term is defined in section 3(24) of the Act, and a statement describing any other conditions which must be met before a participant will be eligible to receive benefits. Such plan benefits shall be described or summarized. In addition, the summary plan description shall include a description of the procedures governing qualified domestic relations order (QDRO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

(2) For employee welfare benefit plans, it shall also include a statement of the conditions pertaining to eligibility to receive benefits, and a description or summary of the benefits. In the case of a welfare plan providing extensive schedules of benefits (a group health plan, for example), only a general description of such benefits is required if reference is made to detailed schedules of benefits which are available without cost to any participant or beneficiary who so requests. In addition, the summary plan description shall include a description of the procedures governing qualified medical child support order (QMCSO) determinations or a statement indicating that participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

(3) For employee welfare benefit plans that are group health plans, as defined in section 733(a)(1) of the Act, the summary plan description shall include a description of: any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits under the plan; the extent to which preventive services are covered under the plan; whether, and under what circumstances, existing and new drugs are covered under the plan; whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of specialty medical care; any conditions or limits applicable to obtaining emergency medical care; and any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the plan. In the case of plans with provider networks, the listing of providers may be furnished as a separate document that accompanies the plan’s SPD, provided that the summary plan description contains a general description of the provider network and provided further that the SPD contains a statement that provider lists are furnished automatically.
(k) In the case of an employee pension benefit plan, a statement describing any joint and survivor benefits provided under the plan, including any requirement that an election be made as a condition to select or reject the joint and survivor annuity:

(l) For both pension and welfare benefit plans, a statement clearly identifying circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that a participant or beneficiary might otherwise reasonably expect the plan to provide on the basis of the description of benefits required by paragraphs (j) and (k) of this section. In addition to other required information, plans must include a summary of any plan provisions governing the authority of the plan sponsors or others to terminate the plan or amend or eliminate benefits under the plan and the circumstances, if any, under which the plan may be terminated or benefits may be amended or eliminated; a summary of any plan provisions governing the benefits, rights and obligations of participants and beneficiaries under the plan on termination of the plan or amendment or elimination of benefits under the plan, including, in the case of an employee pension benefit plan, a summary of any provisions relating to the accrual and the vesting of pension benefits under the plan upon termination; and a summary of any plan provisions governing the allocation and disposition of assets of the plan upon termination. Plans also shall include a summary of any provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or on an individual account thereof, the payment of which is a condition to the receipt of benefits under the plan. The foregoing summaries shall be disclosed in accordance with the requirements under 29 CFR 2520.102-2(b).

(m) For an employee pension benefit plan the following information:

(1) If the benefits of the plan are not insured under title IV of the Act, a statement of this fact, and reason for the lack of insurance; and

(2) If the benefits of the plan are insured under title IV of the Act, a statement of this fact, a summary of the pension benefit guaranty provisions of title IV, and a statement indicating that further information on the provisions of title IV can be obtained from the plan administrator or the Pension Benefit Guaranty Corporation. The address of the PBGC shall be provided.

(3) A summary plan description for a single-employer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

Your pension benefits under this plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan’s normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC depending on how much money your plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC’s Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005–4026 or call 202–326–4000 (not a toll-free number). TTY/TDD users may call the federal relay service.
§ 2520.102–3
29 CFR Ch. XXV (7–1–15 Edition)
toll-free at 1–800–877–8339 and ask to be connected to 202–326–4000. Additional information about the PBGC’s pension insurance program is available through the PBGC’s website on the Internet at http://www.pbgc.gov.

(4) A summary plan description for a multiemployer plan will be deemed to comply with paragraph (m)(2) of this section if it includes the following statement:

Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry.

Under the multiemployer plan program, the PBGC provides financial assistance through loans to plans that are insolvent. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC’s guaranteed benefit limit) when due.

The maximum benefit that the PBGC guarantees is set by law. Under the multiemployer program, the PBGC guarantee equals a participant’s years of service multiplied by (1) 100% of the first $5 of the monthly benefit accrual rate and (2) 75% of the next $15. The PBGC’s maximum guarantee limit is $16.25 per month times a participant’s years of service. For example, the maximum annual guarantee for a retiree with 30 years of service would be $5,850.

The PBGC guarantee generally covers: (1) Normal and early retirement benefits; (2) disability benefits if you become disabled before the plan becomes insolvent; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) Benefits greater than the maximum guaranteed amount set by law; (2) benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the earlier of: (i) The date the plan terminates or (ii) the time the plan becomes insolvent; (3) benefits that are not vested because you have not worked long enough; (4) benefits for which you have not met all of the requirements at the time the plan becomes insolvent; and (5) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC’s Technical Assistance Division, 1220 K Street, N.W., Suite 930, Washington, D.C. 20005–4526 or call 202–326–4000 (not a toll-free number). TTY/TDD users may call the federal relay service toll-free at 1–800–877–8339 and ask to be connected to 202–326–4000. Additional information about the PBGC’s pension insurance program is available through the PBGC’s website on the Internet at http://www.pbgc.gov.

(n) In the case of an employee pension benefit plan, a description and explanation of the plan provisions for determining years of service for eligibility to participate, vesting, and breaks in service, and years of participation for benefit accrual. The description shall state the service required to accrue full benefits and the manner in which accrual of benefits is prorated for employees failing to complete full service for a year.

(o) In the case of a group health plan, within the meaning of section 607(1) of the Act, subject to the continuation coverage provisions of Part 6 of Title 1 of ERISA, a description of the rights and obligations of participants and beneficiaries with respect to continuation coverage, including, among other things, information concerning qualifying events and qualified beneficiaries, premiums, notice and election requirements and procedures, and duration of coverage.

(p) The sources of contributions to the plan—for example, employer, employee organization, employees—and the method by which the amount of contribution is calculated. Defined benefit pension plans may state without further explanation that the contributio is actuarially determined.

(q) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall identify any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided. If a health insurance issuer, within the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.
(r) The date of the end of the year for purposes of maintaining the plan’s fiscal records;
(s) The procedures governing claims for benefits (including procedures for obtaining preauthorizations, approvals, or utilization review decisions in the case of group health plan services or benefits, and procedures for filing claim forms, providing notifications of benefit determinations, and reviewing denied claims in the case of any plan), applicable time limits, and remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 503 of Title I of the Act). The plan’s claims procedures may be furnished as a separate document that accompanies the plan’s SPD, provided that the document satisfies the style and format requirements of 29 CFR 2520.102–2 and, provided further that the SPD contains a statement that the plan’s claims procedures are furnished automatically, without charge, as a separate document.
(t)(1) The statement of ERISA rights described in section 104(c) of the Act, containing the items of information applicable to the plan included in the model statement of paragraph (t)(2) of this section. Items which are not applicable to the plan are not required to be included. The statement may contain explanatory and descriptive provisions in addition to those prescribed in paragraph (t)(2) of this section. However, the style and format of the statement shall not have the effect of misleading, misinforming or failing to inform participants and beneficiaries of a plan. All such information shall be written in a manner calculated to be understood by the average plan participant, taking into account factors such as the level of comprehension and education of typical participants in the plan and the complexity of the items required under this subparagraph to be included in the statement. Inaccurate, incomprehensible or misleading explanatory material will fail to meet the requirements of this section. The statement of ERISA rights (the model statement or a statement prepared by the plan), must appear as one consolidated statement. If a plan finds it desirable to make additional mention of certain rights elsewhere in the summary plan description, it may do so. The summary plan description may state that the statement of ERISA rights is required by Federal law and regulation.
(2) A summary plan description will be deemed to comply with the requirements of paragraph (t)(1) of this section if it includes the following statement; items of information which are not applicable to a particular plan should be deleted:
As a participant in (name of plan) you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:
RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS
Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report. Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age ***) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide the statement free of charge.
CONTINUE GROUP HEALTH PLAN COVERAGE
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may

511
§ 2520.102–3

29 CFR Ch. XXV (7–1–15 Edition)

have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer within 30 days after you first lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a (pension, welfare) benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relative, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

(u) (1) For a group health plan, as defined in section 733(a)(1) of the Act, that provides maternity or newborn infant coverage, a statement describing any requirements under federal or state law applicable to the plan, and any health insurance coverage offered under the plan, relating to hospital length of stay in connection with childbirth for the mother or newborn child. If federal law applies in some areas in which the plan operates and state law applies in other areas, the statement should describe the different areas and the federal or state law requirements applicable in each.

(2) In the case of a group health plan subject to section 711 of the Act, the summary plan description will be deemed to have complied with paragraph (u)(1) of this section relating to the required description of federal law requirements if it includes the following statement in the summary plan description:

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.
Employee Benefits Security Admin., Labor

§ 2520.103–1

Contents of the annual report.

(a) In general. The administrator of a plan required to file an annual report in accordance with section 104(a)(1) of the Act shall include with the annual report the information prescribed in paragraph (a)(1) of this section or in the simplified report, limited exemption or alternative method of compliance described in paragraph (a)(2) of this section.

(b) Contents of the annual report for plans with 100 or more participants electing the limited exemption or alternative method of compliance. Except as provided in paragraph (d) and paragraph (f) of this section and in §§ 2520.103–2 and 2520.104–44, the annual report of an employee benefit plan covering 100 or more participants at the beginning of the plan year which elects the limited exemption or alternative method of compliance shall file an annual report containing the information prescribed in paragraph (b) or paragraph (c) of this section, as applicable, and shall furnish a summary annual report as prescribed in § 2520.104b–10.

513
compliance described in paragraph (a)(2) of this section shall include:

1. A Form 5500 “Annual Return/Report of Employee Benefit Plan” and any statements or schedules required to be attached to the form, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule SB (Single-Employer Defined Benefit Plan Actuarial Information), Schedule MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information), Schedule C (Service Provider Information), Schedule D (DFE/Participating Plan Information), Schedule G (Financial Transaction Schedules), Schedule H (Financial Information), Schedule R (Retirement Plan Information), and other financial schedules described in Sec. 2520.103-10. See the instructions for this form.

2. Separate financial statements (in addition to the information required by paragraph (b)(1) of this section), if such financial statements are prepared in order for the independent qualified public accountant to form the opinion required by section 103(a)(3)(A) of the Act and §2520.103-1(b)(5). These statements shall include the following:

   (i) A statement of assets and liabilities at current value presented in comparative form for the beginning and end of the year. The statement of plan assets and liabilities shall include the assets and liabilities required to be reported on the Form 5500; however, the assets and liabilities may be aggregated into categories in a manner other than that used on Form 5500.

   (ii) Separate or combined statements of plan income and expenses and of changes in net assets which include the categories of income, expense, and changes in assets required to be reported on the Form 5500; however the income, expense, and changes in net assets may be aggregated into categories in a manner other than that used on Form 5500.

3. Notes to the financial statements described in paragraph (b)(1) or (2) of this section which contain a description of the accounting principles and practices reflected in the financial statements and, if applicable, variances from generally accepted accounting principles; a description of the plan, including any significant changes in the plan made during the period and the impact of such changes on benefits; the funding policy (including policy with respect to prior service cost) and any changes in such policy from the prior year, a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; an explanation of the differences, if any, between the information contained in the separate financial statements and the assets, liabilities, income, expenses and changes in the net assets as required to be reported on the Form 5500, and any other matters necessary to fully and fairly present the financial condition of the plan.

4. In the case of a plan, some or all of the assets of which are held in a pooled separate account maintained by an insurance company, or a common or collective trust maintained by a bank or similar institution, a copy of the annual statement of assets and liabilities of such account or trust for the fiscal year of the account or trust which ends with or within the plan year for which the annual report is made as required to be furnished to the administrator by such account or trust under §2520.103-5(c). Although the statement of assets and liabilities referred to in §2520.103-5(c) shall be considered part of the plan’s annual report, such statement of assets and liabilities need not be filed with the plan’s annual report. See §§2520.103-3 and 2520.103-4 for reporting requirements for plans some or all of the assets of which are held in a pooled separate account maintained by an insurance company, or a common or collective trust maintained by a bank or similar institution.

5. A report of an independent qualified public accountant.

   (i) Technical requirements. The accountant’s report—

   (A) Shall be dated;

   (B) Shall be signed manually;

   (C) Shall indicate the city and state where issued; and
(D) Shall identify without detailed enumeration the financial statements and schedules covered by the report.

(ii) Representations as to the audit. The accountant’s report—

(A) Shall state whether the audit was made in accordance with generally accepted auditing standards; and

(B) Shall designate any auditing procedures deemed necessary by the accountant under the circumstances of the particular case which have been omitted, and the reasons for their omission. Authority for the omission of certain procedures which independent accountants might ordinarily employ in the course of an audit made for the purpose of expressing the opinions required by paragraph (b)(5)(iii) of this section is contained in §§ 2520.103–8 and 2520.103–12.

(iii) Opinion to be expressed. The accountant’s report shall state clearly:

(A) The opinion of the accountant in respect of the financial statements and schedules covered by the report and the accounting principles and practices reflected therein; and

(B) The opinion of the accountant as to the consistency of the application of the accounting principles with the application of such principles in the preceding year or as to any changes in such principles which have a material effect on the financial statements.

(iv) Exceptions. Any matters to which the accountant takes exception shall be clearly identified, the exception thereto specifically and clearly stated, and, to the extent practicable, the effect of the matters to which the accountant takes exception on the related financial statements. The matters to which the accountant takes exception shall be further identified as (A) those that are the result of DOL regulations, and (B) all others.

(c) Contents of the annual report for plans with fewer than 100 participants.

(1) Except as provided in paragraph (c)(2), paragraph (d) and paragraph (f) of this section, and in §§ 2520.104–43, 2520.104–46, and 2520.104–44, the annual report of an employee benefit plan that covers fewer than 100 participants at the beginning of the plan year shall include a Form 5500 “Annual Return/Report of Employee Benefit Plan” and any statements or schedules required to be attached to the form, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule SB (Single Employer Defined Benefit Plan Actuarial Information), Schedule MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information), Schedule D (DFE/Participating Plan Information), Schedule I (Financial Information—Small Plan), and Schedule R (Retirement Plan Information). See the instructions for this form.

(2)(i) The annual report of an employee benefit plan that covers fewer than 100 participants at the beginning of the plan year and that meets the conditions in paragraph (c)(2)(ii) of this section with respect to a plan year may, as an alternative to the requirements of paragraph (c)(1) of this section, meet its annual reporting requirements by filing the Form 5500–SF “Short Form Annual Return/Report of Small Employee Benefit Plan” and any statements or schedules required to be attached to the form, including Schedule SB (Single Employer Defined Benefit Plan Actuarial Information) and Schedule MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information), completed in accordance with the instructions for the form. See the instructions for this form.

(ii) A plan meets the conditions in this paragraph (c)(2)(ii) with respect to the year if the plan:

(A) Does not hold any employer securities at any time during the year;

(B) Satisfies the audit waiver conditions in §§ 2520.104–46(b)(1)(i)(A)(1), (b)(1)(i)(B) and (b)(1)(i)(C);

(C) Had at all times during the plan year 100 percent of the plan’s assets held for investment purposes invested in assets that have a readily determinable fair market value. For purposes of this section, the following shall be treated as assets that have a readily determinable fair market value: Shares issued by an investment company registered under the Investment Company Act of 1940; investment and annuity contracts issued by any insurance company, qualified to do business under the laws of a State, that provides valuation information at least
§ 2520.103-2

annually to the plan administrator; bank investment contracts issued by a bank or similar financial institution, as defined in §2550.408b-4(c) of this chapter, that provides valuation information at least annually to the plan administrator; securities (except employer securities) traded on a public exchange; government securities issued by the United States or by a State; cash or cash equivalents held by a bank or similar financial institution, as defined in §2550.408b-4(c) of this chapter, by an organization registered as a broker-dealer under the Securities Exchange Act of 1934, or by any other organization authorized to act as a trustee for individual retirement accounts under section 408 of the Internal Revenue Code; and any loan meeting the requirements of section 408(b)(1) of the Act and the regulations issued thereunder;

(D) Is not a multiemployer plan; and

(E) Is not a plan subject to the Form M–1 requirements under §2520.101–2 (Filing by Multiple Employer Welfare Arrangements and Certain Other Related Entities).

(d) Special rule. If a plan has between 80 and 120 participants (inclusive) as of the beginning of the plan year, the plan administrator may elect to file the same category of annual report (i.e., the annual report for plans with 100 or more participants under paragraph (b) of this section or the annual report for plans with fewer than 100 participants under paragraph (c) of this section) that was filed for the previous plan year.

(e) Plans which participate in a master trust. The plan administrator of a plan which participates in a master trust shall file an annual report on Form 5500 in accordance with the instructions for the form relating to master trusts and master trust investment accounts. For purposes of annual reporting, a master trust is a trust for which a regulated financial institution serves as trustee or custodian (regardless of whether such institution exercises discretionary authority or control respecting the management of assets held in the trust) and in which assets of more than one plan sponsored by a single employer or by a group of employers under common control are held. For purpose of this paragraph, a regulated financial institution is a bank, trust company, or similar financial institution regulated, supervised, and subject to periodic examination by a State or Federal agency. Common control is determined on the basis of all relevant facts and circumstances (whether or not such employers are incorporated).

(1) Plans subject to the Form M–1 filing requirements under §2520.101–2. The annual report of an employee welfare benefit plan that is subject to the Form M–1 requirements under §2520.101–2 (Filing by Multiple Employer Welfare Arrangements and Certain Other Related Entities) during the plan year shall also include any statements or information required by the instructions to the Form 5500 relating to compliance with the Form M–1 filing requirements under §2520.101–2.

(g) Electronic filing. See §2520.104a–2 and the instructions for the Form 5500 “Annual Return/Report of Employee Benefit Plan” for electronic filing requirements. The plan administrator must maintain an original copy, with all required signatures, as part of the plan’s records.

Employee Benefits Security Admin., Labor

§2520.103–2

Plan Information), Schedule G (Financial Transaction Schedules), Schedule H (Financial Information), and the other financial schedules described in §2520.103–10. See the instructions for this form.

(2) Separate financial statements (in addition to the information required by paragraph (b)(1) of this section), if such financial statements are prepared in order for the independent qualified public accountant to form the opinion required by section 103(a)(3)(A) of the Act and §2520.103–2(b)(5). These financial statements shall include the following:

(i) A statement of all trust assets and liabilities at current value presented in comparative form for the beginning and end of the year. The statement of trust assets and liabilities shall include the assets and liabilities required to be reported on the Form 5500; however, the assets and liabilities may be aggregated into categories in a manner other than that used on Form 5500.

(ii) Separate or combined statements of all trust income and expenses and changes in net assets which includes the categories of income, expense, and changes in assets required to be reported on the Form 5500; however, the income, expense, and changes in assets may be aggregated into categories in a manner other than that used on Form 5500.

(3) Notes to the financial statements described in paragraph (b)(1) or (2) of this section which contain a description of the accounting principles and practices reflected in the financial statements and, if applicable, variances from generally accepted accounting principles; a description of the group insurance arrangement including any significant changes in the group insurance arrangement made during the period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with persons known to be parties in interest; a general description of priorities upon termination of the plan; an explanation of the differences, if any, between the information contained in the separate financial statements and the assets, liabilities, income, expenses and changes in net assets as required to be reported on the Form 5500; and any other matters necessary to fully and fairly present the financial condition of the plan.

(4) In the case of a group insurance arrangement some or all of the assets of which are held in a pooled separate account maintained by an insurance carrier, or in a common or collective trust maintained by a bank, trust company or similar institution, a copy of the annual statement of assets and liabilities of such account or trust for the fiscal year of the account or trust which ends with or within the plan year for which the annual report is made as required to be furnished by such account or trust under §2520.103–5(c). Although the statement of assets and liabilities referred to in §2520.103–5(c) shall be considered part of the group insurance arrangement’s annual report, such statement of assets and liabilities need not be filed with its annual report. See §§2520.103–3 and 2520.103–4 for reporting requirements for plans some or all of the assets of which are held in a pooled separate account maintained by an insurance company, or a common or collective trust maintained by a bank or similar institution, and see §2520.104–43(b)(2) for when the terms “group insurance arrangement” or “trust or other entity” shall be, respectively, used in place of the terms “plan” and “plan administrator.”

(5) A report of an independent qualified public accountant.

(i) Technical requirements. The accountant’s report—

(A) Shall be dated;

(B) Shall be signed manually;

(C) Shall indicate the city and State where issued; and

(D) Shall identify without detailed enumeration the financial statements and schedules covered by the report.

(ii) Representations as to the audit. The accountant’s report—

(A) Shall state whether the audit was made in accordance with generally accepted auditing standards; and

(B) Shall designate any auditing procedures deemed necessary by the accountant under the circumstances of the particular case, which have been omitted, and the reasons for their
§ 2520.103–3 Exemption from certain annual reporting requirements for assets held in a common or collective trust.

(a) General. Under the authority of sections 103(b)(3)(G), 103(b)(4), 104(a)(2)(B), 104(a)(3), 110 and 505 of the Act, a plan whose assets are held in whole or in part in a common or collective trust maintained by a bank, trust company, or similar institution which meets the requirements of paragraph (b) of this section shall include as part of the annual report required to be filed under §§ 2520.104a–5 or 2520.104a–6 the information described in paragraph (c) of this section. Such plan is not required to include in its annual report information concerning the individual transactions of the common or collective trust. This exemption has no application to assets not held in such trusts.

(b) Application. This provision applies only to a plan some or all of the assets of which are held in a common or collective trust maintained by a bank, trust company, or similar institution regulated and supervised and subject to periodic examination by a State or Federal agency. For purposes of this section,

(1) A common or collective trust is a trust which consists of the assets of two or more participating entities and is maintained for the collective investment and reinvestment of assets contributed thereto, and

(2) Plans maintained by a single employer or by the members of a controlled group of corporations, as defined in section 1563(a) of the Internal Revenue Code of 1954, shall be deemed to be a single participating entity.

(c) Contents. (1) A plan which meets the requirements of paragraph (b) of this section, and which invests in a common or collective trust that files a Form 5500 report in accordance with §2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of and net investment gain or loss relating to the units of participation in the common or collective trust held by the plan; identifying information about the common or collective trust including its name, employer identification number, and any other information required by the instructions to the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan’s units of participation in the common or collective trust and transactions involving the acquisition and
disposition by the plan of units of participation in the common or collective trust.

(2) A plan which meets the requirements of paragraph (b) of this section, and which invests in a common or collective trust that does not file a Form 5500 report in accordance with §2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of the plan’s allocable portion of the underlying assets and liabilities of the common or collective trust and the net investment gain or loss relating to the units of participation in the common or collective trust held by the plan; identifying information about the common or collective trust including its name, employer identification number, and any other information required by the instructions to the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan’s units of participation in the common or collective trust and transactions involving the acquisition and disposition by the plan of units of participation in the common or collective trust.

§2520.103–4 Exemption from certain annual reporting requirements for assets held in an insurance company pooled separate account.

(a) General. Under the authority of sections 103(b)(3)(G), 103(b)(4), 104(a)(2)(B), 104(a)(3), 110 and 505 of the Act, a plan whose assets are held in whole or in part in a pooled separate account of an insurance carrier which meets the requirements of paragraph (b) of this section shall include as part of the annual report required to be filed under §2520.104a–6 or §2520.104a–6 the information described in paragraph (c) of this section. Such plan is not required to include in its annual report information concerning the individual transactions of the pooled separate account. This exemption has no application to assets not held in such a pooled separate account.

(b) Application. This provision applies only to a plan some or all of the assets of which are held in a pooled separate account of an insurance carrier regulated and supervised and subject to periodic examination by a State agency. For purposes of this section, (1) a pooled separate account is an account which consists of the assets of two or more participating entities and is maintained for the collective investment and reinvestment of assets contributed thereto, and (2) plans maintained by a single employer or by members of a controlled group of corporations, as defined in section 1563(a) of the Internal Revenue Code of 1954, shall be deemed to be a single participating entity.

(c) Contents. (1) A plan which meets the requirements of paragraph (b) of this section, and which invests in a pooled separate account that files a Form 5500 report in accordance with §2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of, and net investment gain or loss relating to, the units of participation in the pooled separate account held by the plan; identifying information about the pooled separate account including its name, employer identification number, and any other information required by the instructions to the Schedule D (DFE/Participating Plan Information); and such other information as is required in the separate statements and schedules of the annual report about the value of the plan’s units of participation in the pooled separate accounts and transactions involving the acquisition and disposition by the plan of units of participation in the pooled separate account.

(2) A plan which meets the requirements of paragraph (b) of this section, and which invests in a pooled separate account that does not file a Form 5500 report in accordance with §2520.103–9, shall include in its annual report: information required by the instructions to Schedule H (Financial Information) or Schedule I (Financial Information—Small Plan) about the current value of the plan’s allocable portion of the underlying assets and liabilities of the
§ 2520.103–5 Transmittal and certification of information to plan administrator for annual reporting purposes.

(a) General. In accordance with section 103(a)(2) of the Act, an insurance carrier or other organization which provides benefits under the plan or holds plan assets, a bank or similar institution which holds plan assets, or a plan sponsor shall transmit and certify such information as needed by the administrator to file the annual report under section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6:

(1) Within 9 months after the close of the plan year which begins in 1975 or September 30, 1976, whichever is later, and

(2) Within 120 days after the close of any plan year which begins after December 31, 1975.

(b) Application. This requirement applies with respect to—

(1) An insurance carrier or other organization which:

(i) Provides funds from its general asset account for the payment of benefits under a plan, or

(ii) Holds assets of a plan in a separate account and transmits such information as needed by the administrator to file the annual report under section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6:

(A) A copy of the annual statement of assets and liabilities of the separate account for the fiscal year of such account ending with or within the plan year for which the plan administrator is making the filing pursuant to §2520.103–9(c) will be made for the separate account (for its fiscal year ending with or within the participating plan’s plan year) on or before the filing due date for such account in accordance with the Form 5500 instructions, and

(B) A statement of the value of the plan’s units of participation in the separate account,

(C) The Employer Identification Number (EIN) of the separate account, entity number required for purposes of completing the Form 5500 and any other identifying number assigned by the insurance carrier to the separate account,

(D) A statement that a filing pursuant to §2520.103–9(c) will be made for the separate account (for its fiscal year ending with or within the participating plan’s plan year) on or before the filing due date for such account in accordance with the Form 5500 instructions, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the insurance carrier and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6;

(ii) Holds assets of a plan in a pooled separate account and does not file a Form 5500 report pursuant to §2520.103–9 for the participating plan’s plan year—

(A) A copy of the annual statement of assets and liabilities of the separate account for the fiscal year of such account ending with or within the plan year for which the plan administrator is making the filing pursuant to §2520.103–9(c) will be made for the separate account (for its fiscal year ending with or within the participating plan’s plan year) on or before the filing due date for such account in accordance with the Form 5500 instructions, and

(b) Application. This requirement applies with respect to—

(1) An insurance carrier or other organization which:

(i) Provides funds from its general asset account for the payment of benefits under a plan, or

(ii) Holds assets of a plan in a separate account and transmits such information as needed by the administrator to file the annual report under section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6:

(A) A copy of the annual statement of assets and liabilities of the separate account for the fiscal year of such account ending with or within the plan year for which the plan administrator is making the filing pursuant to §2520.103–9(c) will be made for the separate account (for its fiscal year ending with or within the participating plan’s plan year) on or before the filing due date for such account in accordance with the Form 5500 instructions, and

(b) Application. This requirement applies with respect to—

(1) An insurance carrier or other organization which:

(i) Provides funds from its general asset account for the payment of benefits under a plan, or

(ii) Holds assets of a plan in a separate account and transmits such information as needed by the administrator to file the annual report under section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6:

(A) A copy of the annual statement of assets and liabilities of the separate account for the fiscal year of such account ending with or within the plan year for which the plan administrator is making the filing pursuant to §2520.103–9(c) will be made for the separate account (for its fiscal year ending with or within the participating plan’s plan year) on or before the filing due date for such account in accordance with the Form 5500 instructions, and

(b) Application. This requirement applies with respect to—

(1) An insurance carrier or other organization which:

(i) Provides funds from its general asset account for the payment of benefits under a plan, or

(ii) Holds assets of a plan in a separate account and transmits such information as needed by the administrator to file the annual report under section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6:
Employee Benefits Security Admin., Labor

§ 2520.103–5

account for the fiscal year of such account that ends with or within the plan year for which the participating plan’s annual report is made,

(B) A statement of the value of the plan’s units of participation in the separate account,

(C) The EIN of the separate account and any other identifying number assigned by the insurance carrier to the separate account,

(D) A statement that a filing pursuant to §2520.103–9(c) will not be made for the separate account for its fiscal year ending with or within the participating plan’s plan year, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the insurance carrier and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6.

(iv) Holds assets of a plan in a separate account which is not exempted from certain reporting requirements under §2520.103–4, a listing of all transactions of the separate account and, upon request of the plan administrator, such information as is contained within the ordinary business records of the insurance carrier and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and §2520.104a–5 or §2520.104a–6.

(2) In the case of a bank, trust company, or similar institution holding assets of a plan—

(i) In a common or collective trust that files a Form 5500 report pursuant to §2520.103–9 for the participating plan’s plan year—

(A) A copy of the annual statement of assets and liabilities of the common or collective trust for the fiscal year of such account that ends with or within the plan year for which the participating plan’s annual report is made,

(B) A statement of the value of the plan’s units of participation in the common or collective trust,

(C) The EIN of the common or collective trust, entity number assigned for purposes of completing the Form 5500 and any other identifying number assigned by the bank, trust company, or similar institution,

(D) A statement that a filing pursuant to §2520.103–9(c) will be made for the common or collective trust (for its fiscal year ending with or within the participating plan’s plan year) on or before the filing due date for such trust in accordance with the Form 5500 instructions, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the bank, trust company or similar institution and that is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and §§2520.104a–5 or 2520.104a–6.

(ii) In a common or collective trust that does not file a Form 5500 report pursuant to §2520.103–9 for the participating plan’s plan year—

(A) A copy of the annual statement of assets and liabilities of the common or collective trust for the fiscal year of such account that ends with or within the plan year for which the participating plan’s annual report is made,

(B) A statement of the value of the plan’s units of participation in the common or collective trust,

(C) The EIN of the common or collective trust and any other identifying number assigned by the bank, trust company or similar institution,

(D) A statement that a filing pursuant to §2520.103–9(c) will not be made for the common or collective trust for its fiscal year ending with or within the participating plan’s plan year, and

(E) Upon request of the plan administrator, any other information that can be obtained from the ordinary business records of the bank, trust company or similar institution,

(iii) In a trust which is not exempted from certain reporting requirements under §2520.103–3, a listing of all transactions of the separate trust and, upon request of the plan administrator, such information as is contained within the ordinary business records of the bank, trust company, or similar institution
§ 2520.103–6

and is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5.

(iv) In a custodial account, upon request of the plan administrator, such information as is contained within the ordinary business records of the bank, trust company, or similar institution and is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6.

(3) In the case of a plan sponsor, a listing of all transactions directly or indirectly involving plan assets engaged in by the plan sponsor and such information as is needed by the plan administrator to comply with the requirements of section 104(a)(1) of the Act and § 2520.104a–5 or § 2520.104a–6.

(d) Certification. (1) An insurance carrier or other organization, a bank, trust company, or similar institution, or plan sponsor, as described in paragraph (b) of this section, shall certify to the accuracy and completeness of the information described in paragraph (c) of this section by a written declaration which is signed by a person authorized to represent the insurance carrier, bank, or plan sponsor. Such certification will serve as a written assurance of the truth of the facts stated therein.

(2) Example of Certification. The XYZ Bank (Insurance Carrier) hereby certifies that the foregoing statement furnished pursuant to 29 CFR 2520.103–5(c) is complete and accurate.


§ 2520.103–6 Definition of reportable transaction for Annual Return/Report.

(a) General. For purposes of preparing the schedule of reportable transactions described in § 2520.103–10(b)(6), and subject to the exceptions provided in §§ 2520.103–3, 2520.103–4 and 2520.103–12, with respect to individual transactions by a common or collective trust, pooled separate account, or a 103–12 investment entity, a reportable transaction includes any transaction or series of transactions described in paragraph (c) of this section.

(b) Definitions. (1)(i) Except as provided in paragraphs (c)(2) and (d)(1)(vi) of this section (relating to assets acquired or disposed of during the plan year), “current value” shall mean the current value, as defined in section 3(26) of the Act, of plan assets as of the beginning of the plan year, or the end of the previous plan year.

(ii) Except as provided in paragraphs (c)(2) and (d)(1)(vi) of this section (relating to assets acquired or disposed of during the plan year), with respect to schedules of reportable transactions for the initial plan year of a plan, “current value” shall mean the current value, as defined in section 3(26) of the Act, of plan assets at the end of a plan’s initial plan year.

(2)(i) A “transaction with respect to securities” is any purchase, sale, or exchange of securities. A transaction with respect to securities for purposes of this section occurs on either the trade date or settlement date of a purchase, sale, or exchange of securities; either the trade date or settlement date must be used consistently during the plan year for the purposes of this section. For the purposes of this section, except as provided in paragraph (b)(2)(ii) of this section, “securities” includes a unit of participation in a common or collective trust or a pooled separate account.

(ii) Solely for purposes of paragraph (c)(1)(iv) of this section, the term “securities”, as it applies to any transaction involving a bank or insurance company regulated by a Federal or State agency, an investment company registered under the Investment Company Act of 1940, or a broker-dealer registered under the Securities Exchange Act of 1934, shall not include:

(A) Debt obligations of the United States or any United States agency with a maturity of not more than one year;

(B) Debt obligations of the United States or any United States agency with a maturity of more than one year if purchased or sold under a repurchase agreement having a term of less than 91 days;

(C) Interests issued by a company registered under the Investment Company Act of 1940;
Employee Benefits Security Admin., Labor § 2520.103–6

(D) Bank certificates of deposit with a maturity of not more than one year;

(E) Commercial paper with a maturity of not more than nine months if it is ranked in the highest rating category for commercial paper by at least two nationally recognized statistical rating services and is issued by a company required to file reports under section 13 of the Securities Exchange Act of 1934;

(F) Participations in a bank common or collective trust;

(G) Participations in an insurance company pooled separate account;

(3)(i) Except as provided by paragraph (b)(3)(ii) of this section, a transaction is “with or in conjunction with a person” for purposes of this section if that person benefits from, executes, facilitates, participates, promotes, or solicits a transaction or part of a transaction involving plan assets.

(ii) Solely for the purposes of paragraph (c)(1)(iv) of this section, a transaction shall not be considered “with or in conjunction with a person” if:

(A) That person is a broker-dealer registered under the Securities Exchange Act of 1934;

(B) The transaction involves the purchase or sale of securities listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 or quoted on NASDAQ; and

(C) The broker-dealer does not purchase or sell securities involved in the transaction for its own account or the account of an affiliated person.

(c) Application. (1) Except as provided in paragraph (c)(4) of this section, this provision applies to—

(i) A transaction within the plan year, with respect to any plan asset, involving an amount in excess of 3 percent of the current value of plan assets;

(ii) Any series of transactions (other than transactions with respect to securities) within the plan year with or in conjunction with the same person which, when aggregated, regardless of the category of asset and the gain or loss on any transaction, involves an amount in excess of 3 percent of the current value of plan assets;

(iii) Any transaction within the plan year involving securities of the same issue if within the plan year any series of transactions with respect to such securities, when aggregated, involves an amount in excess of 3 percent of the current value of plan assets; and

(iv) Any transaction within the plan year with respect to securities with or in conjunction with a person if any prior or subsequent single transaction within the plan year with such person with respect to securities exceeds 3 percent of the current value of plan assets.

(2) For purposes of determining whether any 3 percent transactions occur, the “current value” of an asset acquired or disposed of during the plan year is the current value, as defined in section 3(26) of the Act, at the time of acquisition or disposition of such asset.

(3) Plans whose assets are held in whole or in part in a common or collective trust or a pooled separate account, as provided in §§2520.103–3 and 2520.103–4, and which satisfy the requirements of those sections, are not required to prepare schedules of reportable transactions with respect to the individual transactions of the common or collective trust or pooled separate account.

(4) For plan years beginning on or after January 1, 1988, 5 percent shall be substituted for 3 percent in paragraphs (c)(1) and (2) of this section for purposes of determining whether a transaction or series of transactions constitutes a reportable transaction under this section.

(d) Contents. (1) The schedule of transactions shall include the following information as to each transaction or series of transactions:

(i) The name of each party, except that in the case of a transaction or series of transactions involving a purchase or sale of a security on the market, the schedule need not include the person from whom it was purchased or to whom it was sold. A purchase or sale on the market is a purchase or sale of a security through a registered broker-dealer acting as a broker under the Securities Exchange Act of 1934;

(ii) A brief description of each asset;

(iii) The purchase or selling price in the case of a purchase or sale, the rental in the case of a lease, and the amount of principal, interest rate, payment schedule (e.g., fully amortized, partly amortized with balloon) and maturity date in the case of a loan;
(iv) Expenses incurred, including, but not limited to, any fees or commissions;
(v) The cost of any asset;
(vi) The current value of any asset acquired or disposed of at the time of acquisition or disposition; and
(vii) The net gain or loss.
(2) The schedule of transactions with respect to a series of transactions described in paragraph (c)(1)(iii) may include the following information for each issue in lieu of the information prescribed in paragraphs (d)(1)(i) through (vii):
(i) The total number of purchases of such securities made by the plan within the plan year;
(ii) The total number of sales of such securities made by the plan within the plan year;
(iii) The total dollar value of such purchases;
(iv) The total dollar value of such sales;
(v) The net gain or loss as a result of these transactions.

(e) Examples. These examples are effective for reporting for plan years beginning on or after January 1, 1988.

(1) At the beginning of the plan year, XYZ plan has 10 percent of the current value of its plan assets invested in ABC common stock. Halfway through the plan year, XYZ purchases ABC common stock in a single transaction in an amount equal to 6 percent of the current value of plan assets. At about this time, XYZ plan also purchases a commercial development property in an amount equal to 8 percent of the current value of plan assets. Under paragraph (c)(1)(i) of this section, the 6 percent stock transaction is a reportable transaction for the plan year because it exceeds 5 percent of the current value of plan assets. The 8 percent land transaction is also reportable under paragraph (c)(1)(i) of this section because it exceeds 5 percent of the current value of plan assets.

(2) During the plan year, AAA plan purchases a commercial lot from ZZZ corporation at a cost equal to 2 percent of the current value of the plan assets. Two months later, AAA plan loans ZZZ corporation an amount of money equal to 3.5 percent of the current value of plan assets. Under the provisions of paragraph (c)(1)(ii) of this section, AAA has engaged in a reportable series of transactions with or in conjunction with the same person, ZZZ corporation, which when aggregated involves 5.5 percent of plan assets.

(3) During the plan year NMN plan sells to OPO corporation a commercial property that represents 3.5 percent of the current value of plan assets. OPO simultaneously executes a note and mortgage on the purchased property to NMN which represents 3 percent of the current value of plan assets. Under the provisions of paragraph (c)(1)(ii) of this section, NMN has engaged in a reportable series of transactions with or in conjunction with the same person, OPO corporation, consisting of a simultaneous sale of property and a loan, which, when aggregated, involves 6.5 percent of the current value of plan assets.

(4) At the beginning of the plan year, ABC plan has 10 percent of the current value of plan assets invested equally in a combination of XYZ Corporation common stock and XYZ preferred stock. One month into the plan year, ABC sells some of its XYZ common stock in an amount equal to 2 percent of the current value of plan assets. The sale of XYZ common stock is not reportable because only transactions involving securities of the same issue are to be aggregated under paragraph (c)(1)(iii) of this section.

(5) At the beginning of the plan year, Plan X purchases through broker-dealer Y common stock of Able Industries in an amount equal to 6 percent of plan assets. The common stock of Able Industries is not listed on any national securities exchange or quoted on
NASDQAQ. This purchase is a reportable transaction under paragraph (c)(1)(i) of this section. Three months later, Plan X purchases short term debt obligations of Charley Company through broker-dealer Y in the amount of 0.2 percent of plan assets. This purchase is also a reportable transaction under the provisions of paragraph (c)(1)(iv) of this section.

(6) At the beginning of the plan year, Plan X purchases from Bank B certificates of deposit having a 180 day maturity in an amount equal to 6 percent of plan assets. Bank B is a national bank regulated by the Comptroller of the Currency. This purchase is a reportable transaction under paragraph (c)(1)(i) of this section. Three months later, Plan X purchases through Bank B 91-day Treasury bills in the amount of 0.2 percent of plan assets. This purchase is not a reportable transaction under paragraph (c)(1)(iv) of this section because the purchase of the Treasury bills as well as the purchase of the certificates of deposit are not considered to involve a security under the definition of “securities” in paragraph (b)(2)(ii) of this section.

(7) At the beginning of the plan year, Plan X purchases through broker-dealer Y common stock of Able Industries, a New York Stock Exchange listed security, in an amount equal to 6 percent of plan assets. This purchase is a reportable transaction under paragraph (c)(1)(i) of this section. Three months later, Plan X purchases through broker-dealer Y, acting as agent, common stock of Baker Corporation, also a New York Stock Exchange listed security, in an amount equal to 0.2 percent of plan assets. This latter purchase is not a reportable transaction under paragraph (c)(1)(iv) of this section because it is not a transaction “with or in conjunction with a person” pursuant to paragraph (b)(3)(ii) of this section.

§ 2520.103–9 Direct filing for bank or insurance carrier trusts and accounts.

(a) General. Under the authority of sections 103(b)(4), 104(a)(3), 110 and 505 of the Act, an employee benefit plan, some or all of the assets of which are held in a common or collective trust or a pooled separate account described in section 103(b)(3)(G) of the Act and §§ 2520.103–3 and 2520.103–4, is relieved of the requirement of including in its annual report information about the current value of the plan’s allocable portion of assets and liabilities of the common or collective trust or pooled separate account and information concerning the individual transactions of the common or

§ 2520.103–8 Limitation on scope of accountant’s examination.

(a) General. Under the authority of section 103(a)(3)(C) of the Act, the examination and report of an independent qualified public accountant need not extend to any statements or information prepared and certified by a bank or similar institution or insurance carrier. A plan, trust or other entity which meets the requirements of paragraph (b) of this section is not required to have covered by the accountant’s examination or report any of the information described in paragraph (c) of this section.

(b) Application. This section applies as well as the provisions or all of the assets of which are held by a bank or similar institution or insurance carrier which is regulated and supervised and subject to periodic examination by a State or Federal agency.

(c) Excluded information. Any statements or information certified to by a bank or similar institution or insurance carrier described in paragraph (b) of this section, provided that the statements or information regarding assets so held are prepared and certified to by the bank or insurance carrier in accordance with § 2520.103–3.

§ 2520.103–9 Direct filing for bank or insurance carrier trusts and accounts.

(a) General. Under the authority of sections 103(b)(4), 104(a)(3), 110 and 505 of the Act, an employee benefit plan, some or all of the assets of which are held in a common or collective trust or a pooled separate account described in section 103(b)(3)(G) of the Act and §§ 2520.103–3 and 2520.103–4, is relieved of the requirement of including in its annual report information about the current value of the plan’s allocable portion of assets and liabilities of the common or collective trust or pooled separate account and information concerning the individual transactions of the common or
§ 2520.103–10 Annual report financial schedules.

(a) General. The administrator of a plan filing an annual report pursuant to §2520.103–1(a)(2) or the report for a group insurance arrangement pursuant to §2520.103–2 shall, as provided in the instructions to the Form 5500 "Annual Return/Report of Employee Benefit Plan," include as part of the annual report the separate financial schedules described in paragraph (b) of this section.

(b) Schedules—(1) Assets held for investment. (i) A schedule of all assets held for investment purposes at the end of the plan year (see §2520.103–11) with assets aggregated and identified by:
   (A) Identity of issue, borrower, lessor or similar party to the transaction (including a notation as to whether such party is known to be a party in interest);
   (B) Description of investment including maturity date, rate of interest, collateral, par, or maturity value;
   (C) Cost; and
   (D) Current value, and, in the case of a loan, the payment schedule.
   (ii) Except as provided in the Form 5500 and the instructions thereto, in the case of assets or investment interests of two or more plans maintained in one trust, all entries on the schedule of assets held for investment purposes that relate to the trust shall be completed by including the plan’s allocable portion of the trust.

(2) Assets acquired and disposed within the plan year. (i) A schedule of all assets acquired and disposed of within the plan year (see §2520.103–11) with assets aggregated and identified by:
   (A) Identity of issue, borrower, issuer or similar party;
   (B) Descriptions of investment including maturity date, rate of interest, collateral, par, or maturity value;
   (C) Cost of acquisitions; and
   (D) Proceeds of dispositions.
   (ii) Except as provided in the Form 5500 and the instructions thereto, in the case of assets or investment interests of two or more plans maintained in one trust, all entries on the schedule of assets held for investment purposes that relate to the trust shall be completed by including the plan’s allocable portion of the trust.

§ 2520.103–10

collective trust or pooled separate account, provided that the plan meets the requirements of paragraph (b) of this section, and, provided further, that the bank or insurance carrier which holds the plan’s assets meets the requirements of paragraph (c) of this section.

(b) Application. A plan whose assets are held in a common or collective trust or a pooled separate account described in section 103(b)(3)(G) of the Act and §§2520.103–3 and 2520.103–4, provided the plan administrator, on or before the end of the plan year, provides the bank or insurance carrier which maintains the common or collective trust or pooled separate account with the plan number, and name and Employer Identification Number of the plan sponsor as will be reported on the plan’s annual report.

(c) Separate filing by common or collective trusts and pooled separate accounts. The bank or insurance carrier which maintains the common or collective trust or pooled separate account in which assets of the plan are held shall file, in accordance with the instructions for the form, a completed Form 5500 “Annual Return/Report of Employee Benefit Plan” and any statements or schedules required to be attached to the form for the common or collective trust or pooled separate account, including Schedule D (DFE/Participating Plan Information) and Schedule H (Financial Information). See the instructions for this form. The information reported shall be for the fiscal year of such trust or account ending with or within the plan year for which the annual report of the plan is made.

(d) Electronic filing. See §2520.104a–2 and the instructions for the Form 5500 “Annual Return/Report of Employee Benefit Plan” for electronic filing requirements. The bank or insurance company which maintains the common or collective trust or pooled separate account must maintain an original copy, with all required signatures, as part of its records.

[65 FR 21082, Apr. 19, 2000, as amended at 71 FR 41368, July 21, 2006]
§ 2520.103–11 Assets held for investment purposes.

(a) General. For purposes of preparing the schedule of assets held for investment purposes described in §2520.103–10(b)(1) and (2), assets held for investment purposes include those assets described in paragraph (b) of this section.

(b) Definitions. (1) Assets held for investment purposes shall include:

(i) Any investment asset held by the plan on the last day of the plan year; and

(ii) Any investment asset which was purchased at any time during the plan year and was sold at any time before the last day of the plan year, except as provided by paragraphs (b)(2) and (b)(3) of this section.

(2) Assets held for investment purposes shall not include any investment which was not held by the plan on the last day of the plan year which the annual report is filed if that investment falls within any of the following categories:

(i) Debt obligations of the United States or any agency of the United States;

(ii) Interests issued by a company registered under the Investment Company Act of 1940;

(iii) Bank certificates of deposit with a maturity of not more than one year;

(iv) Commercial paper with a maturity of not more than nine months if it is ranked in the highest rating category by at least two nationally recognized statistical rating services and is issued by a company required to file reports with the Securities and Exchange Commission under section 13 of the Securities Exchange Act of 1934;

(v) Participations in a bank common or collective trust;

(vi) Participations in an insurance company pooled separate account;

(vii) Securities purchased from a person registered as a broker-dealer under the Securities Exchange Act of 1934 and listed on a national securities exchange registered under section 6 of the Securities Exchange Act of 1934 or quoted on NASDAQ;

(3) Assets held for investment purposes shall not include any investment which was not held by the plan on the last day of the plan year for which the annual report is filed if that investment is reported on the annual report of that same plan in any of the following:

(i) The schedule of each transaction involving a person known to be a party in interest required by section 103(b)(3)(D) of the Act and §2520.103–10(b)(3);

(ii) The schedule of loans or fixed income obligations in default required by section 103(b)(3)(E) of the Act and §2520.103–10(b)(4);

(iii) The schedule of leases in default or classified as uncollectible required by section 103(b)(3)(F) of the Act and §2520.103–10(b)(5); or

(iv) The schedule of reportable transactions required by section 103(b)(3)(H) of the Act and §2520.103–10(b)(6).

(c) Examples. (1) On February 1, 1977, plan N purchases an interest in registered investment company F (fund F). Fund F is not a party in interest with respect to plan N. On November 1,
1977, plan N sells this interest in fund F and purchases 1,000 shares of stock S, which the plan holds for the rest of the plan year. Plan N must include in its schedule of assets held for investment purposes the 1,000 shares of stock S under paragraph (b)(1) of this section, but need not include the interest in fund F because of paragraph (b)(2)(ii) of this section.

(2) On February 1, 1977, plan N purchases a parcel of real estate from Mr. M, who is not a party in interest with respect to plan N. On November 1, 1977, plan N sells the parcel of real estate for cash to Mr. X, who is not a party in interest with respect to plan N. Plan N uses the cash from this transaction to purchase a 1-year certificate of deposit in bank B, which it holds until maturity in 1978. Plan N must include in its schedule of assets held for investment purposes the 1-year certificate of deposit in bank B under paragraph (b)(1)(i) of this section, and must also include the parcel of real estate under paragraph (b)(1)(ii) of this section.

(d) Special rule for certain participant-directed transactions. Cost information may be omitted from the schedule of assets held for investment purposes the 1-year certificate of deposit in bank B under paragraph (b)(1)(i) of this section, and must also include the parcel of real estate under paragraph (b)(1)(ii) of this section only with respect to participant or beneficiary directed transactions under an individual account plan. For purposes of this section only, a transaction will be considered directed by a participant or beneficiary if it has been authorized by such participant or beneficiary.

§ 2520.103–12 Limited exemption and an alternative method of compliance for annual reporting of investments in certain entities.

(a) This section prescribes an exemption from and alternative method of compliance with the annual reporting requirements of part 1 of title I of ERISA for employee benefit plans whose assets are invested in certain entities described in paragraph (c). A plan utilizing this method of reporting shall include as part of its annual report the current value of its investment or units of participation in the entity in the manner prescribed by the Return/Report Form and the instructions thereto. The plan is not required to include in its annual report any information regarding the underlying assets or individual transactions of the entity provided the information described in paragraph (b) regarding the entity is reported directly to the Department on behalf of the plan administrator on or before the filing due date for the entity in accordance with the instructions to the Form 5500 Annual Return/Report. The information described in paragraph (b), however, shall be considered as part of the annual report for purposes of the requirements of section 104(a)(1) of the Act and §§ 2520.104a–5 and 2520.104a–6.

(b) The following information must be filed regarding the entity described in paragraph (c) of this section:

(1) A Form 5500 “Annual Return/Report of Employee Benefit Plan” and any statements or schedules required to be attached to the form for such entity, completed in accordance with the instructions for the form, including Schedule A (Insurance Information), Schedule C (Service Provider Information), Schedule D (DFE/Participating Plan Information), Schedule G (Financial Transaction Schedules), Schedule H (Financial Information), and the schedules described in §2520.103–10(b)(1) and (b)(2). See the instructions for this form. The information reported shall be for the fiscal year of such entity ending with or within the plan year for which the annual report of the plan is made.

(2) A report of an independent qualified public accountant regarding the financial statements and schedules described in paragraph (b)(1) of this section which meets the requirements of §2520.103–1(b)(5).

(c) This method of reporting is available to any employee benefit plan which has invested in an entity the assets of which are deemed to include plan assets under §2510.3–101, provided the entity holds the assets of two or more plans which are not members of a “related group” of employee benefit plans as that term is defined in paragraph (e) of this section. The method of reporting is not available for investments in an insurance company pooled...
Employee Benefits Security Admin., Labor  § 2520.103–13

§ 2520.103–13 Special terminal report for abandoned plans.

(a) General. The terminal report required to be filed by the qualified termination administrator pursuant to §2578.1(d)(2)(viii) of this chapter shall consist of the items set forth in paragraph (b) of this section. Such report shall be filed in accordance with the method of filing set forth in paragraph (c) of this section and at the time set forth in paragraph (d) of this section.

(b) Contents. The terminal report described in paragraph (a) of this section shall contain:

1. Identification information concerning the qualified termination administrator and the plan being terminated.

2. The total assets of the plan as of the date the plan was deemed terminated under §2578.1(c) of this chapter, prior to any reduction for termination expenses and distributions to participants and beneficiaries.

3. The total termination expenses paid by the plan and a separate schedule identifying each service provider and amount received, itemized by expense.

4. The total distributions made pursuant to §2578.1(d)(2)(vii) of this chapter and a statement regarding whether any such distributions were transfers under §2578.1(d)(2)(vii)(B) of this chapter.

5. The identification, fair market value and method of valuation of any assets with respect to which there is no readily ascertainable fair market value.

(c) Method of filing. The terminal report described in paragraph (a) shall be filed:

1. On the most recent Form 5500 available as of the date the qualified termination administrator satisfies the requirements in §2578.1(d)(2)(i) through §2578.1(d)(2)(vii) of this chapter; and

2. In accordance with the Form’s instructions pertaining to terminal reports of qualified termination administrators.

(d) When to file. The qualified termination administrator shall file the terminal report described in paragraph (a) within two months after the end of the month in which the qualified termination administrator satisfies the requirements in §2578.1(d)(2)(i) through §2578.1(d)(2)(vii) of this chapter.

(e) Limitation. (1) Except as provided in this section, no report shall be required to be filed by the qualified termination administrator under part 1 of
§ 2520.104–1

title I of ERISA for a plan being terminated pursuant to §2578.1 of this chapter.

(2) Filing of a report under this section by the qualified termination administrator shall not relieve any other person from any obligation under part 1 of title I of ERISA.

[71 FR 20853, Apr. 21, 2006]

Subpart D—Provisions Applicable to Both Reporting and Disclosure Requirements

(The information collection requirements contained in subpart D were approved by the Office of Management and Budget under control number 1210–0016)

§ 2520.104–1 General.

The administrator of an employee benefit plan covered by part 1 of title I of the Act must file reports and additional information with the Secretary of Labor, and disclose reports, statements, and documents to plan participants and to beneficiaries receiving benefits from the plan. The regulations contained in this subpart are applicable to both the reporting and disclosure requirements of part 1 of title I of the Act. Regulations concerning only a plan administrator’s duty of reporting to the Secretary of Labor are set forth in subpart E of this part, and those applicable only to the duty of disclosure to participants and beneficiaries are set forth in subpart F of this part.

[41 FR 16962, Apr. 23, 1976]

§§ 2520.104–2—2520.104–3 [Reserved]

§ 2520.104–4 Alternative method of compliance for certain successor pension plans.

(a) General. Under the authority of section 110 of the Act, this section sets forth an alternative method of compliance for certain successor pension plans in which some participants and beneficiaries not only have their rights set out in the plan, but also retain eligibility for certain benefits under the terms of a former plan which has been merged into the successor. This section is applicable only to plan mergers which occur after the issuance by the successor plan of the initial summary plan description under the Act. Under the alternative method, the plan administrator of the successor plan is not required to describe relevant provisions of merged plans in summary plan descriptions of the successor plan furnished after the merger to that class of participants and beneficiaries still affected by the terms of the merged plans.

(b) Scope and application. This alternative method of compliance is available only if:

(1) The plan administrator of the successor plan furnishes to the participants covered under the predecessor plan and beneficiaries receiving pension benefits under the merged plan within 90 days after the effective date of the merger:

(i) A copy of the most recent summary plan description of the successor plan;

(ii) A copy of any summaries of material modifications to the successor plan not incorporated in the most recent summary plan description; and

(iii) A separate statement containing a brief description of the merger, a description of the provisions of, and benefits provided by, the merged and successor plans which are applicable to the participants and beneficiaries of the merged plan; and a notice that copies of the merged and successor plan documents, as well as the plan merger documents (including the portions of any corporate merger documents which describe or control the plan merger), are available for inspection and that copies may be obtained upon written request for a duplication charge (pursuant to §2520.104b–30); and

(2) After the merger, the plan administrator, in all subsequent summary plan descriptions furnished pursuant to §2520.104b–2(a)–

(i) Clearly and conspicuously identifies the class of participants and beneficiaries affected by the provisions of the merged plan, and

(ii) States that the documents described in paragraph (b)(1) of this section are available for inspection and that copies may be obtained upon written request for a duplication charge (pursuant to §2520.104b–30).

§ 2520.104–20 Limited exemption for certain small welfare plans.

(a) Scope. Under the authority of section 104(a)(3) of the Act, the administrator of any employee welfare benefit plan which covers fewer than 100 participants at the beginning of the plan year and which meets the requirements of paragraph (b) of this section is exempted from certain reporting and disclosure provisions of the Act. Specifically, the administrator of such plan is not required to file with the Secretary an annual or terminal report. In addition, the administrator of a plan exempted under this section—

1. Is not required to furnish participants receiving benefits under the plan with statements of the plan’s assets and liabilities and receipts and disbursements and a summary of the annual report required by section 104(b)(3) of the Act;

2. Is not required to furnish upon written request of any participant or beneficiary a copy of the annual report and any terminal report, as required by section 104(b)(4) of the Act;

3. Is not required to make copies of the annual report available for examination by any participant or beneficiary in the principal office of the administrator and such other places as may be necessary, as required by section 104(b)(2) of the Act;

(b) Application. This exemption applies only to welfare benefit plans—

1. Which have fewer than 100 participants at the beginning of the plan year;

2. (i) For which benefits are paid as needed solely from the general assets of the employer or employee organization maintaining the plan, or

(ii) The benefits of which are provided exclusively through insurance contracts or policies issued by an insurance company or similar organization which is qualified to do business in any State or through a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e–9(d), the premiums for which are paid directly by the employer or employee organization from its general assets or partly from its general assets and partly from contributions by its employees or members.

(c) Limitations. This exemption does not exempt the administrator of an employee benefit plan from any other requirement of title I of the Act, including the provisions which require that plan administrators furnish copies of the summary plan description to participants and beneficiaries (section 104(b)(1)) and furnish certain documents to the Secretary of Labor upon request (section 104(a)(6)), and which authorize the Secretary of Labor to collect information and data from employee benefit plans for research and analysis (section 513).

(d) Examples. (1) A welfare plan has 75 participants at the beginning of the plan year and 105 participants at the end of the plan year. Plan benefits are fully insured and premiums are paid directly to the insurance company by the employer pursuant to an insurance contract purchased with premium payments derived half from the general assets of the employer and half from employee contributions (which the employer forwards within three months of receipt). Refunds to the plan are paid to participating employees within three months of receipt as provided in the plan and as described to each participant upon entering the plan. The plan appoints the employer as its plan administrator. The employer, as plan administrator, provides summary plan documents and maintains the plan records.
§ 2520.104–21 Limited exemption for certain group insurance arrangements.

(a) Scope. Under the authority of section 104(a)(3) of the Act, the administrator of any employee welfare benefit plan which covers fewer than 100 participants at the beginning of the plan year and which meets the requirements of paragraph (b) of this section is exempted from certain reporting and disclosure provisions of the Act. Specifically, the administrator of such plan is not required to file a terminal report or furnish upon written request of any participant or beneficiary a copy of any terminal report as required by section 104(b)(4) of the Act.

(b) Application. This exemption applies only to welfare plans, each of which has fewer than 100 participants at the beginning of the plan year and which are part of a group insurance arrangement if such arrangement:

(1) Provides benefits to the employees of two or more unaffiliated employers, but not in connection with a multiemployer plan as defined in section 3(37) of the Act and any regulations prescribed under the Act concerning section 3(37);

(2) Fully insures one or more welfare plans of each participating employer through insurance contracts purchased solely by the employers or purchased partly by the employers and partly by their participating employees, with all benefit payments made by the insurance company; Provided, That—

(i) Contributions by participating employers are forwarded by the employers within three months of receipt,

(ii) Refunds, to which contributing participants are entitled, are returned to them within three months of receipt, and

(iii) Contributing participants are informed upon entry into the plan of the provisions of the plan concerning the allocation of refunds; and

(3) Uses a trust (or other entity such as a trade association) as the holder of the insurance contracts and uses a trust as the conduit for payment of premiums to the insurance company.

(c) Limitations. This exemption does not exempt the administrator of an employee benefit plan from any other requirement of title I of the Act, including the provisions which require that plan administrators furnish copies of the summary plan description to participants and beneficiaries (section 104(b)(1)), file an annual report with the Secretary of Labor (section 104(a)(1)) and furnish certain documents to the Secretary of Labor upon request (section 104(a)(6)), and authorize the Secretary of Labor to collect information and data from employee benefit plans for research and analysis (section 513).

(d) Examples. (1) A welfare plan has 25 participants at the beginning of the plan year. It is part of a group insurance arrangement of a trade association which provides benefits to employees of two or more unaffiliated employers, but not in connection with a multiemployer plan as defined in the Act. Plan benefits are fully insured pursuant to insurance contracts purchased with premium payments derived half from employee contributions (which the employer forwards within three months of receipt) and half from the general assets of each participating employer. Refunds to the plan are paid to participating employees within three months of receipt as provided in the plan and as described to each participant upon entering the plan. The trade association holds the insurance
Employee Benefits Security Admin., Labor § 2520.104–22

contracts. A trust acts as a conduit for payments, receiving premium payments from participating employers and paying the insurance company. The plan appoints the trade association as its plan administrator. The association, as plan administrator, provides summary plan descriptions to participants and beneficiaries, enlisting the help of participating employers in carrying out this distribution. The plan administrator also makes copies of certain plan documents available to the plan’s principal office and such other places as necessary to give participants reasonable access to them. The plan administrator files with the Secretary an annual report covering activities of the plan, as required by the Act and such regulations as the Secretary may issue. The exemption provided by this section applies because the conditions of paragraph (b) have been satisfied.

(2) Assume the same facts as paragraph (d)(1) of this section except that the premium payments for the insurance company are paid from the trust to an independent insurance brokerage firm acting as the agent of the insurance company. The trade association is the holder of the insurance contract. The plan appoints an officer of the participating employer as the plan administrator. The officer, as plan administrator, performs the same reporting and disclosure functions as the administrator in paragraph (d)(1) of this section, enlisting the help of the association in providing summary plan descriptions and necessary information. The exemption provided by this section applies.

(3) The facts are the same as paragraph (d)(1) of this section except the welfare plan has 125 participants at the beginning of the plan year. The exemption provided by this section does not apply because the plan had 100 or more participants at the beginning of the plan year. See, however, § 2520.104–43.

(4) The facts are the same as paragraph (d)(2) of this section except the welfare plan has 125 participants. The exemption provided by this section does not apply because the plan had 100 or more participants at the beginning of the plan year. See, however, § 2520.104–43.

(e) Applicability date. For purposes of paragraph (b)(3) of this section, the arrangement may continue to use an entity (such as a trade association) as the conduit for the payment of insurance premiums to the insurance company for reporting years of the arrangement beginning before January 1, 2001.


§ 2520.104–22 Exemption from reporting and disclosure requirements for apprenticeship and training plans.

(a) An employee welfare benefit plan that provides exclusively apprenticeship training benefits or other training benefits or that provides exclusively apprenticeship and training benefits shall not be required to meet any requirement of part 1 of the Act, provided that the administrator of such plan:

(1) Has filed with the Secretary the notice described in paragraph (b) of this section;

(2) Takes steps reasonably designed to ensure that the information required to be contained in such notice is disclosed to employees of employers contributing to the plan who may be eligible to enroll in any course of study sponsored or established by the plan; and

(3) Makes such notice available to such employees upon request.

(b) The notice referred to in paragraph (a) of this section shall contain accurate information concerning:

(1) The name of the plan;

(2) The Employer Identification Number (EIN) of the plan sponsor;

(3) The name of the plan administrator;

(4) The name and location of an office or person from whom an interested individual can obtain:

(i) A description of any existing or anticipated future course of study sponsored or established by the plan, including any prerequisites for enrolling in such course; and

(ii) A description of the procedure by which to enroll in such course.

(c) Filing address. The notice referred to in paragraph (a) of this section shall be filed with the Secretary of Labor by mailing it to: Apprenticeship and Training Plan Exemption, Employee
§ 2520.104–23 Alternative method of compliance for pension plans for certain selected employees.

(a) Purpose and scope. (1) This section contains an alternative method of compliance with the reporting and disclosure requirements of part 1 of title I of the Employee Retirement Income Security Act of 1974 for unfunded or insured pension plans maintained by an employer for a select group of management or highly compensated employees, pursuant to the authority of the Secretary of Labor under section 110 of the Act (88 Stat. 851).

(2) Under section 110 of the Act, the Secretary is authorized to prescribe an alternative method for satisfying any requirement of part 1 of title I of the Act with respect to any pension plans, or class of pension plans, subject to such requirement.

(b) Filing obligation. Under the authority of section 110 of the Act, an alternative method of compliance with the reporting and disclosure requirements of part 1 of the Act is provided for certain pension plans for a select group of management or highly compensated employees. The administrator of a pension plan described in paragraph (d) of this section shall be deemed to satisfy the reporting and disclosure provisions of part 1 of title I of the Act by—

(1) Filing a statement with the Secretary of Labor that includes the name and address of the employer, the employer identification number (EIN) assigned by the Internal Revenue Service, a declaration that the employer maintains a plan or plans primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, and a statement of the number of such plans and the number of employees in each, and

(2) Providing plan documents, if any, to the Secretary upon request as required by section 104(a)(6) of the Act. Only one statement need be filed for each employer maintaining one or more of the plans described in paragraph (d) of this section. For plans in existence on May 4, 1975, the statement shall be filed on or before August 31, 1975. For a plan to which part 1 of title I of the Act becomes applicable after May 4, 1975, the statement shall be filed within 120 days after the plan becomes subject to part 1.

(c) Filing address. Statements may be filed with the Secretary of Labor by mailing them addressed to: Top Hat Plan Exemption, Employee Benefits Security Administration, Room N–1513, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC.

(d) Application. The alternative form of compliance described in paragraph (b) of this section is available only to employee pension benefit plans—

(1) Which are maintained by an employer primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, and

(2) For which benefits (i) are paid as needed solely from the general assets of the employer, (ii) are provided exclusively through insurance contracts or policies, the premiums for which are paid directly by the employer from its general assets, issued by an insurance company or similar organization which is qualified to do business in any State, or (iii) both.

§ 2520.104–24 Exemption for welfare plans for certain selected employees.

(a) Purpose and scope. (1) This section, under the authority of section 104(a)(3) of the Employee Retirement Income Security Act of 1974, exempts unfunded
or insured welfare plans maintained by an employer for the purpose of providing benefits for a select group of management or highly compensated employees from the reporting and disclosure provisions of part 1 of title I of the Act, except for the requirement to provide plan documents to the Secretary of Labor upon request under section 104(a)(1) of the Act.

(2) Under section 104(a)(3) of the Act, the Secretary is authorized to exempt by regulation any welfare benefit plan from all or part of the reporting and disclosure requirements of title I of the Act.

(b) Exemption. Under the authority of section 104(a)(3) of the Act, each employee welfare benefit plan described in paragraph (c) of this section is exempted from the reporting and disclosure provisions of part 1 of title I of the Act, except for providing plan documents to the Secretary of Labor upon request as required by section 104(a)(6).

(c) Application. This exemption is available only to employee welfare benefit plans:

(1) Which are maintained by an employer primarily for the purpose of providing benefits for a select group of management or highly compensated employees, and

(2) For which benefits (i) are paid as needed solely from the general assets of the employer, (ii) are provided exclusively through insurance contracts or policies, the premiums for which are paid directly by the employer from its general assets, issued by an insurance company or similar organization which is qualified to do business in any State, or (iii) both.

[40 FR 34533, Aug. 15, 1975, as amended at 67 FR 776, Jan. 7, 2002]

§ 2520.104–25 Exemption from reporting and disclosure for day care centers.

Under the authority of section 104(a)(3) of the Act, day care centers are exempted from the reporting and disclosure provisions of part 1 of title I of the Act, except for providing plan documents to the Secretary upon request as required under section 104(a)(6) of the Act.

[40 FR 34533, Aug. 15, 1975, as amended at 67 FR 776, Jan. 7, 2002]

§ 2520.104–26 Limited exemption for certain unfunded dues financed welfare plans maintained by employee organizations.

(a) Scope. Under the authority of section 104(a)(3) of the Act, a welfare benefit plan that meets the requirements of paragraph (b) of this section is exempted from the provisions of the Act that require filing with the Secretary an annual report and furnishing a summary annual report to participants and beneficiaries. Such plans may use a simplified method of reporting and disclosure to comply with the requirement to furnish a summary plan description to participants and beneficiaries, as follows:

(1) In lieu of filing an annual report with the Secretary or distributing a summary annual report, a filing is made of Report Form LM–2 or LM–3, pursuant to the Labor-Management Reporting and Disclosure Act (LMRDA) and regulations thereunder, and

(2) In lieu of a summary plan description, the employee organization constitution or by-laws may be furnished in accordance with §2520.104b–2 to participants and beneficiaries together with any supplement to such document necessary to meet the requirements of §§2520.102–2 and 2520.102–3.

(b) Application. This exemption is available only to welfare benefit plans maintained by an employee organization, as that term is defined in section 3(4) of the Act, paid for out of the employee organization's general assets, which are derived wholly or partly from membership dues, and which cover employee organization members and their beneficiaries.

(c) Limitations. This exemption does not exempt the administrator from any other requirement of part 1 of title I of the Act.


§ 2520.104–27 Alternative method of compliance for certain unfunded dues financed pension plans maintained by employee organizations.

(a) Scope. Under the authority of section 110 of the Act, a pension benefit plan that meets the requirements of
paragraph (b) of this section is exempted from the provisions of the Act that require filing with the Secretary an annual report and furnishing a summary annual report to participants and beneficiaries receiving benefits. Such plans may use a simplified method of reporting and disclosure to comply with the requirement to furnish a summary plan description to participants and beneficiaries receiving benefits, as follows:

(1) In lieu of filing an annual report with the Secretary or distributing a summary annual report, a filing is made of Report Form LM–2 or LM–3, pursuant to the Labor-Management Reporting and Disclosure Act (LMRDA) and regulations thereunder, and

(2) In lieu of a summary plan description, the employee organization constitution or bylaws may be furnished in accordance with §2520.104b–2 to participants and beneficiaries together with any supplement to such document necessary to meet the requirements of §§2520.102–2 and 2520.102–3.

(b) Application. This exemption is available only to pension benefit plans maintained by an employee organization, as that term is defined in section 3(4) of the Act, paid for out of the employee organization’s general assets, which are derived wholly or partly from membership dues, and which cover employee organization members and their beneficiaries.

(c) Limitations. This exemption does not exempt the administrator from any other requirement of part 1 of title I of the Act.


§ 2520.104–28 [Reserved]

§ 2520.104–41 Simplified annual reporting requirements for plans with fewer than 100 participants.

(a) General. (1) Under the authority of section 104(a)(2)(A) of ERISA, the Secretary of Labor may prescribe simplified annual reporting for employee pension benefit plans with fewer than 100 participants.

(2) Under the authority of section 104(a)(3), the Secretary of Labor may provide a limited exemption for any employee welfare benefit plan with respect to certain annual reporting requirements.

(b) Application. The administrator of an employee pension or welfare benefit plan which covers fewer than 100 participants at the beginning of the plan year and the administrator of an employee pension or welfare benefit plan described in §2520.103–1(d) may file the simplified annual report described in paragraph (c) of this section in lieu of the annual report described in §2520.103–1(b).

(c) Contents. The administrator of an employee pension or welfare benefit plan described in paragraph (b) of this section shall file, in the manner described in §2520.104a–5, a completed Form 5500 “Annual Return/Report of Employee Benefit Plan” including, if applicable, the information described in §2520.103–1(f) or, to the extent eligible, a completed Form 5500–SF “Short Form Annual Return/Report of Small Employee Benefit Plan,” and any required schedules or statements prescribed by the instructions to the applicable form, and, unless waived by §§2520.104–44 or §2520.104–46, a report of an independent qualified public accountant meeting the requirements of §2520.103–1(b).


§ 2520.104–42 Waiver of certain actuarial information in the annual report.

Under the authority of section 104(a)(2)(A) of ERISA, the requirement of section 103(d)(6) of ERISA that the annual report include as part of the actuarial statement (Schedule B)¹ the present value of all of the plan’s liabilities for nonforfeitable pension benefits allocated by termination priority categories, as set forth in section 4044 of title IV of ERISA, and the actuarial assumptions used in these computations, is waived.

[44 FR 5446, Jan. 26, 1979]

¹ Schedule B was filed as part of the original document.
§ 2520.104–43 Exemption from annual reporting requirement for certain group insurance arrangements.

(a) General. Under the authority of section 104(a)(3) of the Act, the administrator of an employee welfare benefit plan which meets the requirements of paragraph (b) of this section is not required to file an annual report with the Secretary of Labor as required by section 104(a)(1) of the Act.

(b) Application. (1) This exemption applies only to a welfare plan for a plan year in which (i) such plan meets the requirements of §2520.104–21, except the requirement that the plan cover fewer than 100 participants at the beginning of the plan year, and

(ii) An annual report containing the items set forth in §2520.103–2 has been filed with the Secretary of Labor in accordance with §2520.104a–6 by the trust or other entity which is the holder of the group insurance contracts by which plan benefits are provided.

(2) For purposes of this section, the terms “group insurance arrangement” or “trust or other entity” shall be used in place of the terms “plan” and “plan administrator,” as applicable, in §§2520.103–3, 2520.103–4, 2520.103–6, 2520.103–8, 2520.103–9 and 2520.103–10.

(c) Limitation. This provision does not exempt the administrator of an employee benefit plan which meets the requirements of paragraph (b) from furnishing a copy of a summary annual report to participants and beneficiaries of the plan, as required by section 104(b)(3) of the Act.


§ 2520.104–44 Limited exemption and alternative method of compliance for annual reporting by unfunded plans and by certain insured plans.

(a) General. (1) Under the authority of section 104(a)(3) of the Act, the Secretary of Labor may exempt an employee welfare benefit plan from any or all of the reporting and disclosure requirements of title I. An employee welfare benefit plan which meets the requirements of paragraph (b) of this section is not required to comply with the annual reporting requirements described in paragraph (c) of this section.

(2) Under the authority of section 110 of the Act, an alternative method of compliance is prescribed for certain employee pension benefit plans subject to part 1, title I of the Act. An employee pension benefit plan which meets the requirements of paragraph (b)(2) or (b)(3) of this section is not required to comply with the annual reporting requirements described in paragraph (c) of this section.

(b) Application. This section applies only to:

(1) An employee welfare benefit plan under the terms of which benefits are to be paid—

(i) Solely from the general assets of the employer or employee organization maintaining the plan;

(ii) The benefits of which are provided exclusively through insurance contracts or policies issued by an insurance company or similar organization which is qualified to do business in any State or through a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e–9(d), the premiums for which are paid directly by the employer or employee organization from its general assets or partly from contributions by its employees or members, provided that any plan assets held by such an insurance company are held solely in the general account of such company or organization, contributions by participants are forwarded by the employer or employee organization within three months of receipt and, in the case of a plan that provides for the return of refunds to contributing participants, such refunds are returned to them within three months of receipt by the employer or employee organization, or

(iii) Partly in the manner specified in paragraph (b)(1)(i) of this section and partly in the manner specified in paragraph (b)(1)(ii) of this section; and

(2) A pension benefit plan the benefits of which are provided exclusively through allocated insurance contracts or policies which are issued by, and pursuant to the specific terms of such contracts or policies benefit payments are fully guaranteed by an insurance company or similar organization which is qualified to do business in any State,
and the premiums for which are paid directly by the employer or employee organization from its general assets or partly from its general assets and partly from contributions by its employees or members: Provided, That contributions by participants are forwarded by the employer or employee organization to the insurance company or organization within three months of receipt and, in the case of a plan that provides for the return of refunds to contributing participants, such refunds are returned to them within three months of receipt by the employer or employee organization.

(c) Contents. An employee benefit plan described in paragraph (b) of this section is exempt from complying with the following annual reporting requirements:

(1) Completing certain items of the annual report relating to financial information and transactions entered into by the plan as described in the instructions to the Form 5500 “Annual Return/Report of Employee Benefit Plan” and accompanying schedules;

(2) Engaging an independent qualified public accountant pursuant to section 108(a)(3)(A) of the Act and § 2520.103–1(b) to conduct an examination of the financial statements and schedules of the plan; and

(3) Including in the annual report a report of an independent qualified public accountant concerning the financial statements and schedules required to be a part of the annual report pursuant to section 108(b) of the Act and § 2520.103–1(b).

d) Limitation. This section does not exempt any plan from filing an annual report form with the Secretary in accordance with section 104(a) of the Act and § 2520.104a–5.

e) Example. A welfare plan which is funded entirely with insurance contracts and which meets all the requirements of exemption under § 2520.104–20 except that it covers 100 or more participants at the beginning of the plan year is not exempt from the annual reporting requirements under § 2520.104–20, but is exempt from certain reporting requirements under § 2520.104–44. Under the latter section, such a welfare plan should file Form 5500, including Schedule A “Insurance Information.” However, the plan is not required to engage an independent qualified public accountant and need not complete certain items on form 5500.


§ 2520.104–45 [Reserved]

§ 2520.104–46 Waiver of examination and report of an independent qualified public accountant for employee benefit plans with fewer than 100 participants.

(a) General. (1) Under the authority of section 103(a)(3)(A) of the Act, the Secretary may waive the requirements of section 103(a)(3)(A) in the case of a plan for which simplified annual reporting has been prescribed in accordance with section 104(a)(2) of the Act.

(2) Under the authority of section 104(a)(3) of the Act the Secretary may exempt any employee welfare benefit plan from certain annual reporting requirements.

(b) Application. (1)(i) The administrator of an employee pension benefit plan for which simplified annual reporting has been prescribed in accordance with section 104(a)(2)(A) of the Act and § 2520.104–41 is not required to comply with the annual reporting requirements described in paragraph (c) of this section, provided that with respect to each plan year for which the waiver is claimed—

(A)(J) At least 95 percent of the assets of the plan constitute qualifying plan assets within the meaning of paragraph (b)(1)(ii) of this section, or

(B)(1) At least 95 percent of the assets of the plan constitute qualifying plan assets within the meaning of paragraph (b)(1)(ii) of this section, or

(2) Any person who handles assets of the plan that do not constitute qualifying plan assets is bonded in accordance with the requirements of section 412 of the Act and the regulations issued thereunder, except that the amount of the bond shall not be less than the value of such assets;

(B) The summary annual report (described in § 2520.104–10) or, in the case of plans subject to section 101(f) of the Act, the annual funding notice (described in § 2520.101–5), includes, in addition to any other required information—

(1) Except for qualifying plan assets described in paragraph (b)(1)(ii)(A), (B)
and (F) of this section, the name of each regulated financial institution holding (or issuing) qualifying plan assets and the amount of such assets reported by the institution as of the end of the plan year;

(2) The name of the surety company issuing the bond, if the plan has more than 5% of its assets in non-qualifying plan assets;

(3) A notice indicating that participants and beneficiaries may, upon request and without charge, examine, or receive copies of, evidence of the required bond and statements received from the regulated financial institutions describing the qualifying plan assets; and

(4) A notice stating that participants and beneficiaries should contact the Regional Office of the U.S. Department of Labor’s Employee Benefits Security Administration if they are unable to examine or obtain copies of the regulated financial institution statements or evidence of the required bond, if applicable; and

(C) in response to a request from any participant or beneficiary, the administrator, without charge to the participant or beneficiary, makes available for examination or furnishes copies of, each regulated financial institution statement and evidence of any bond required by paragraph (b)(1)(i)(A)(2).

(ii) For purposes of paragraph (b)(1), the term “qualifying plan assets” means:

(A) Qualifying employer securities, as defined in section 407(d)(5) of the Act and the regulations issued thereunder;

(B) Any loan meeting the requirements of section 408(b)(1) of the Act and the regulations issued thereunder;

(C) Any assets held by any of the following institutions:

(1) A bank or similar financial institution as defined in § 2550.408b-4(c);

(2) An insurance company qualified to do business under the laws of a state;

(3) An organization registered as a broker-dealer under the Securities Exchange Act of 1934; or

(4) Any other organization authorized to act as a trustee for individual retirement accounts under section 408 of the Internal Revenue Code;

(D) Shares issued by an investment company registered under the Investment Company Act of 1940;

(E) Investment and annuity contracts issued by any insurance company qualified to do business under the laws of a state; and,

(F) In the case of an individual account plan, any assets in the individual account of a participant or beneficiary over which the participant or beneficiary has the opportunity to exercise control and with respect to which the participant or beneficiary is furnished, at least annually, a statement from a regulated financial institution referred to in paragraphs (b)(1)(ii)(C), (D) or (E) of this section describing the assets held (or issued) by such institution and the amount of such assets.

(iii)(A) For purposes of this paragraph (b)(1), the determination of the percentage of all plan assets consisting of qualifying plan assets with respect to a given plan year shall be made in the same manner as the amount of the bond is determined pursuant to §§2580.412–11, 2580.412–14, and 2580.412–15.

(B) Examples. Plan A, which reports on a calendar year basis, has total assets of $600,000 as of the end of the 1999 plan year. Plan A’s assets, as of the end of year, include: investments in various bank, insurance company and mutual fund products of $520,000; investments in qualifying employer securities of $40,000; participant loans, meeting the requirements of ERISA section 408(b)(1), totaling $20,000; and a $20,000 investment in a real estate limited partnership. Because the only asset of the plan that does not constitute a “qualifying plan asset” is the $20,000 real estate investment and that investment represents less than 5% of the plan’s total assets, no bond would be required under the proposal as a condition for the waiver for the 2000 plan year. By contrast, Plan B also has total assets of $600,000 as of the end of the 1999 plan year, of which $558,000 constitutes “qualifying plan assets” and $42,000 constitutes non-qualifying plan assets. Because 7%—more than 5%—of Plan B’s assets do not constitute “qualifying plan assets,” Plan B, as a condition to electing the waiver for the 2000 plan year, must ensure that it has a fidelity bond in an amount equal to

539
§ 2520.104–46

29 CFR Ch. XXV (7–1–15 Edition)

at least $42,000 covering persons handling non-qualifying plan assets. Inasmuch as compliance with section 412 requires the amount of bonds to be not less than 10% of the amount of all the plan's funds or other property handled, the bond acquired for section 412 purposes may be adequate to cover the non-qualifying plan assets without an increase (i.e., if the amount of the bond determined to be needed for the relevant persons for section 412 purposes is at least $42,000). As demonstrated by the foregoing example, where a plan has more than 5% of its assets in non-qualifying plan assets, the bond required by the proposal is for the total amount of the non-qualifying plan assets, not just the amount in excess of 5%.

(2) The administrator of an employee welfare benefit plan that covers fewer than 100 participants at the beginning of the plan year is not required to comply with annual reporting requirements described in paragraph (c) of this section.

(c) Waiver. The administrator of a plan described in paragraph (b)(1) or (2) of this section is not required to:

(1) Engage an independent qualified public accountant to conduct an examination of the financial statements of the plan;

(2) Include within the annual report the financial statements and schedules prescribed in section 103(b) of the Act and §§ 2520.103–1, 2520.103–2, and 2520.103–10; and

(3) Include within the annual report a report of an independent qualified public accountant as prescribed in section 103(a)(3)(A) of the Act and § 2520.103–1.

(d) Limitations. (1) The waiver described in this section does not affect the obligation of a plan described in paragraph (b) (1) or (2) of this section to file a Form 5500 “Annual Return/Report of Employee Benefit Plan,” including any required schedules or statements prescribed by the instructions to the form. See § 2520.104–41.

(2) For purposes of this section, an employee pension benefit plan for which simplified annual reporting has been prescribed includes an employee pension benefit plan which elects to file a Form 5500 as a small plan pursuant to § 2520.103–1(d) with respect to the plan year for which the waiver is claimed. See § 2520.104–41.

(3) For purposes of this section, an employee welfare benefit plan that covers fewer than 100 participants at the beginning of the plan year includes an employee welfare benefit plan which elects to file a Form 5500 as a small plan pursuant to § 2520.103–1(d) with respect to the plan year for which the waiver is claimed. See § 2520.104–41.

(4) A plan that elects to file a Form 5500 as a large plan pursuant to § 2520.103–1(d) may not claim a waiver under this section.

(e) Model notice. The appendix to this section contains model language for inclusion in the summary annual report to assist plan administrators in complying with the requirements of paragraph (b)(1)(i)(B) of this section to avail themselves of the waiver of examination and report of the independent qualified public accountant for employee benefit plans with fewer than 100 participants. Use of the model language is not mandatory. In order to use the model language in the plan’s summary annual report, administrators must, in addition to any other information required to be in the summary annual report, select among alternative language and add relevant information where appropriate in the model language. Items of information that are not applicable to a particular plan may be deleted. Use of the model language, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (b)(1)(i)(B) of this section.

APPENDIX TO § 2520.104–46—MODEL SUMMARY ANNUAL REPORT NOTICE (PLAN ADMINISTRATORS WILL NEED TO MODIFY THE MODEL TO OMIT INFORMATION THAT IS NOT APPLICABLE TO THE PLAN)

The U.S. Department of Labor's regulations require that an independent qualified public accountant audit the plan’s financial statements unless certain conditions are met for the audit requirement to be waived. This plan met the audit waiver conditions for the plan year beginning (insert year) and therefore has not had an audit performed. Instead, the following information is provided to assist you in verifying that the assets reported on the (Form 5500 or Form 5500-SF—select as applicable) were actually held by the plan.

At the end of the (insert year) plan year, the plan had (include separate entries for
each regulated financial institution holding or issuing qualifying plan assets):

[Set forth amounts and names of institutions as applicable where indicated]. [(insert $ amount) in assets held by (insert name of bank)], [(insert $ amount) in securities held by (insert name of registered broker-dealer)], [(insert $ amount) in shares issued by (insert name of registered investment company)], [(insert $ amount) in investment or annuity contract issued by (insert name of insurance company)].

The plan receives year-end statements from these regulated financial institutions that confirm the above information. [Insert as applicable—The remainder of the plan’s assets were (1) qualifying employer securities, (2) loans to participants, (3) held in individual participant accounts with investments directed by participants and beneficiaries and with account statements from regulated financial institutions furnished to the participant or beneficiary at least annually, or (4) other assets covered by a fidelity bond at least equal to the value of the assets and issued by an approved surety company.]

Plan participants and beneficiaries have a right, on request and free of charge, to get copies of the financial institution year-end statements and evidence of the fidelity bond.

If you want to examine or get copies of the financial institution year-end statements or evidence of the fidelity bond, please contact [insert mailing address and any other available way to request copies such as e-mail and phone number].

If you are unable to obtain or examine copies of the regulated financial institution statements or evidence of the fidelity bond, you may contact the regional office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) for assistance by calling toll-free 1.866.444.EBSA or manufacturing a list of EBSA regional offices can be found at http://www.dol.gov/ebsa.

General information regarding the audit waiver conditions applicable to the plan can be found on the U.S. Department of Labor Web site at http://www.dol.gov/ebsa under the heading “Frequently Asked Questions.”


§ 2520.104–47 Limited exemption and alternative method of compliance for filing of insurance company financial reports.

An administrator of an employee benefit plan to which section 103(e)(2) of the Act applies shall be deemed in compliance with the requirement to include with its annual report a copy of the financial report of the insurance company, insurance service or similar organization, provided that the administrator files a copy of such report within 45 days of receipt of a written request for such report by the Secretary of Labor.

[45 FR 14034, Mar. 4, 1980]

§ 2520.104–48 Alternative method of compliance for model simplified employee pensions—IRS Form 5305–SEP.

Under the authority of section 110 of the Act the provisions of this section are prescribed as an alternative method of compliance with the reporting and disclosure requirements set forth in part 1 of title I of the Employee Retirement Income Security Act of 1974 in the case of a simplified employee pension (SEP) described in section 408(k) of the Internal Revenue Code of 1954 as amended (the Code) that is created by use without modification of Internal Revenue Service (IRS) Form 5305–SEP.

(a) At the time an employee becomes eligible to participate in the SEP (whether at the creation of the SEP or thereafter), the administrator of the SEP (generally the employer establishing and maintaining the SEP) shall furnish the employee with a copy of the completed and unmodified IRS Form 5305–SEP used to create the SEP, including (1) the completed Contribution Agreement, (2) the General Information and Guidelines, and (3) the Questions and Answers.

(b) Following the end of each calendar year the administrator of the SEP shall notify each participant in the SEP in writing of any employer contributions made under the Contribution Agreement to the participant’s individual retirement account or individual retirement annuity (IRA) for that year.

(c) If the employer establishing and maintaining the SEP selects, recommends, or in any other way influences employees to choose a particular IRA or type of IRA into which contributions under the SEP will be made, and if that IRA is subject to restrictions on a participant’s ability to withdraw funds (other than restrictions imposed by the Code that apply to all
IRAs), the administrator of the SEP shall give to each employee, in writing, within 90 days of the adoption of this regulation or at the time such employee becomes eligible to participate in the SEP, whichever is later, a clear explanation of those restrictions and a statement to the effect that other IRAs, into which rollovers or employee contributions may be made, may not be subject to such restrictions.

[45 FR 24869, Apr. 11, 1980]

§ 2520.104–49 Alternative method of compliance for certain simplified employee pensions.

Under the authority of section 110 of the Act, the provisions of this section are prescribed as an alternative method of compliance with the reporting and disclosure requirements set forth in part 1 of title 1 of the Act for a simplified employee pension (SEP) described in section 408(k) of the Internal Revenue Code of 1954 as amended, except for:

A SEP that is created by proper use of Internal Revenue Service Form 5305–SEP, or; a SEP in connection with which the employer who establishes or maintains the SEP selects, recommends or influences its employees to choose the IRAs into which employer contributions will be made and those IRAs are subject to provisions that prohibit withdrawal of funds by participants for any period of time.

(a) At the time an employee becomes eligible to participate in the SEP (whether at the creation of the SEP or thereafter) or up to 90 days after the effective date of this regulation, whichever is later, the administrator of the SEP (generally the employer establishing or maintaining the SEP) shall furnish the employee in writing with:

(1) Specific information concerning the SEP, including:

(i) The requirements for employee participation in the SEP;

(ii) The formula to be used to allocate employer contributions made under the SEP to each participant’s individual retirement account or annuity (IRA);

(iii) The name or title of the individual who is designated by the employer to provide additional information to participants concerning the SEP, and

(iv) If the employer who establishes or maintains the SEP selects, recommends or substantially influences its employees to choose the IRAs into which employer contributions under the SEP will be made, a clear explanation of the terms of those IRAs, such as the rate(s) of return and any restrictions on a participant’s ability to roll over or withdraw funds from the IRAs, including restrictions that allow rollovers or withdrawals but reduce earnings of the IRAs or impose other penalties.

(2) General information concerning SEPs and IRAs, including a clear explanation of:

(i) What a SEP is and how it operates,

(ii) The statutory provisions prohibiting discrimination in favor of highly compensated employees,

(iii) A participant’s right to receive contributions under a SEP and the allowable sources of contributions to a SEP-related IRA (SEP-IRA),

(iv) The statutory limits on contributions to SEP-IRAs,

(v) The consequences of excess contributions to a SEP-IRA and how to avoid excess contributions,

(vi) A participant’s rights with respect to contributions made under a SEP to his or her IRA(s),

(vii) How a participant must treat contributions made under a SEP to his or her IRA(s) for tax purposes,

(viii) The statutory provisions concerning withdrawal of funds from a SEP-IRA and the consequences of a premature withdrawal, and

(ix) A participant’s ability to roll over or transfer funds from a SEP-IRA to another IRA, SEP-IRA, or retirement bond, and how such a rollover or transfer may be effected without causing adverse tax consequences.

(3) A statement to the effect that:

(i) IRAs other than the IRA(s) into which employer contributions will be made under the SEP may provide different rates of return and may have different terms concerning, among other things, transfers and withdrawals of funds from the IRA(s),

(ii) In the event a participant is entitled to make a contribution or rollover...
(iii) Depending on the terms of the IRA into which employer contributions are made, a participant may be able to make rollovers or transfers of funds from that IRA to another IRA.

(4) A description of the disclosure required by the Internal Revenue Service to be made to individuals for whose benefit an IRA is established by the financial institution or other person who sponsors the IRA(s) into which contributions will be made under the SEP.

(5) A statement that, in addition to the information provided to an employee at the time he or she becomes eligible to participate in a SEP, the administrator of the SEP must furnish each participant:

(i) Within 30 days of the effective date of any amendment to the terms of the SEP, a copy of the amendment and a clear written explanation of its effects, and

(ii) No later than the later of:

(A) January 31 of the year following the year for which a contribution is made,

(B) 30 days after a contribution is made, or

(C) 30 days after the effective date of this regulation

written notification of any employer contributions made under the SEP to that participant’s IRA(s).

(6) In the case of a SEP that provides for integration with Social Security

(i) A statement that Social Security taxes paid by the employer on account of a participant will be considered as an employer contribution under the SEP to a participant’s SEP-IRA for purposes of determining the amount contributed to the SEP-IRA(s) of a participant by the employer pursuant to the allocation formula.

(ii) A description of the effect that integration with Social Security would have on employer contributions under a SEP, and

(iii) The integration formula, which may constitute part of the allocation formula required by paragraph (a)(1)(ii) of this section.

(b)(1) The requirements of paragraphs (a)(1)(i), (ii), (iii) and (a)(6)(i) of this regulation may be met by furnishing the SEP agreement to participants, provided that the SEP agreement is written in a manner reasonably calculated to be understood by the average plan participant.

(2) The requirements of paragraph (a)(1)(iv) of this regulation may be met through disclosure materials furnished by the financial institution in which the participant’s IRA is maintained, provided the materials contain the information specified in such paragraph.

(c) No later than the later of:

(1) January 31 of the year following the year for which a contribution is made,

(2) 30 days after a contribution is made, or

(3) 30 days after the effective date of this regulation

the administrator of the SEP shall notify a participant in writing of any employer contributions made under the SEP to the participant’s IRA(s).

(d) Within 30 days of the effective date of any amendment to the terms of the SEP, the administrator shall furnish each participant a copy of the amendment and a clear explanation in writing of its effect.

[46 FR 1264, Jan. 6, 1981]
(b) An explanation why one of the two plan years is of seven or fewer months’ duration; and

(iii) A statement that the annual report for the immediately following plan year will include a report of an independent qualified public accountant with respect to the financial statements and accompanying schedules for both of the two plan years.

(2) The annual report for the second of the two consecutive plan years shall include:

(i) Financial statements and accompanying schedules prepared in conformity with section 103(b) of the Act and regulations promulgated thereunder with respect to both plan years;

(ii) A report of an independent qualified public accountant with respect to the financial statements and accompanying schedules for both plan years; and

(iii) A statement identifying any material differences between the unaudited financial information relating to, and contained in the annual report for, the first of the two consecutive plan years and the audited financial information relating to that plan year contained in the annual report for the immediately following plan year.

(c) Accountant’s examination and report. The examination by the accountant which serves as the basis for the portion of his report relating to the first of the two consecutive plan years may be conducted at the same time as the examination which serves as the basis for the portion of his report relating to the immediately following plan year. The report of the accountant shall be prepared in conformity with section 103(a)(3)(A) of the Act and regulations thereunder.

[46 FR 1265, Jan. 6, 1981]
§ 2520.104a–5 Annual reporting filing requirements.

(a) Filing obligation. Except as provided in §2520.104a–6, the administrator of an employee benefit plan required to file an annual report pursuant to section 104(a)(1) of the Act shall file an annual report containing the items prescribed in §2520.103–1 within:

(1) [Reserved]

(2) Seven months after the close of any plan year which begins after December 31, 1975, unless extended. See “When to file” instructions of the appropriate Annual Return/Report Form.

(b) Where to file. The annual report described in §2520.103–1 shall be filed in accordance with and at the address provided in the instructions to the Annual Return/Report Form.


§ 2520.104a–6 Annual reporting for plans which are part of a group insurance arrangement.

(a) General. A trust or other entity described in §2520.104–43(b) that files an annual report in accordance with the terms of subsections (b) and (c) shall be deemed to have filed such report in accordance with §2520.104–6 for purposes of §2520.104–43.

(b) Date of filing. The annual report shall be filed within:

(1) Eleven and one-half months after the close of the fiscal year of the trust or other entity described in §2520.104–43 which begins in 1975 or December 15, 1977, whichever is later; and

(2) Seven months after the close of the fiscal year of the trust or other entity which begins after December 31, 1975, unless extended. See “When to file” instructions of the appropriate Annual Return/Report Form.

(c) Where to file. The annual report prescribed in §2520.103–2 shall be filed in accordance with and at the address provided in the instructions to the Annual Return/Report Form.


§ 2520.104a–7 [Reserved]

§ 2520.104a–8 Requirement to furnish documents to the Secretary of Labor on request.

(a) In general. (1) Under section 104(a)(6) of the Act, the administrator of an employee benefit plan subject to the provisions of part 1 of title I of the Act is required to furnish to the Secretary, upon request, any documents relating to the employee benefit plan. For purposes of section 104(a)(6) of the Act, the administrator of an employee benefit plan shall furnish to the Secretary, upon service of a written request, a copy of:

(i) The latest updated summary plan description (including any summaries of material modifications to the plan or changes in the information required to be included in the summary plan description); and

(ii) Any other document described in section 104(b)(4) of the Act with respect to which a participant or beneficiary has requested, in writing, a copy from the plan administrator and which the administrator has failed or refused to furnish to the participant or beneficiary.

(2) Multiple requests for document(s). Multiple requests under this section for the same or similar document or documents shall be considered separate requests for purposes of §2560.502c–6(a).

(b) For purposes of this section, a participant or beneficiary will include any individual who is:

(1) A participant or beneficiary within the meaning of ERISA sections 3(7) and 3(8), respectively;

(2) An alternate payee under a qualified domestic relations order (see ERISA section 206(d)(3)(K)) or prospective alternate payee (spouses, former spouses, children or other dependents);

(3) A qualified beneficiary under COBRA (see ERISA section 607(3)) or prospective qualified beneficiary (spouse or dependent child);

(4) An alternate recipient under a qualified medical child support order (see ERISA section 609(a)(2)(C)) or a prospective alternate recipient; or

(5) A representative of any of the foregoing.
(c) Service of request. Requests under this section shall be served in accordance with §2560.502c-6(i).

(d) Furnishing documents. A document shall be deemed to be furnished to the Secretary on the date the document is received by the Department of Labor at the address specified in the request; or, if a document is delivered by certified mail, the date on which the document is mailed to the Department of Labor at the address specified in the request.

[67 FR 784, Jan. 7, 2002]

Subpart F—Disclosure Requirements

(The information collection requirements contained in subpart F were approved by the Office of Management and Budget under control number 1210–0016)

§ 2520.104b–1 Disclosure.

(a) General disclosure requirements. The administrator of an employee benefit plan covered by Title I of the Act must disclose certain material, including reports, statements, notices, and other documents, to participants, beneficiaries and other specified individuals. Disclosure under Title I of the Act generally takes three forms. First, the plan administrator must, by direct operation of law, furnish certain material to all participants covered under the plan and beneficiaries receiving benefits under the plan (other than beneficiaries under a welfare plan) at stated times or if certain events occur. Second, the plan administrator must furnish certain material to individual participants and beneficiaries upon their request. Third, the plan administrator must make certain material available to participants and beneficiaries for inspection at reasonable times and places.

(b) Fulfilling the disclosure obligation. (1) Except as provided in paragraph (e) of this section, where certain material, including reports, statements, notices and other documents, is required under Title I of the Act, or regulations issued thereunder, to be furnished either by direct operation of law or on individual request, the plan administrator shall use measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals. Material which is required to be furnished to all participants covered under the plan and beneficiaries receiving benefits under the plan (other than beneficiaries under a welfare plan) must be sent by a method or methods of delivery likely to result in full distribution. For example, in-hand delivery to an employee at his or her worksite is acceptable. However, in no case is it acceptable merely to place copies of the material in a location frequented by participants. It is also acceptable to furnish such material as a special insert in a periodical distributed to employees such as a union newspaper or a company publication if the distribution list for the periodical is comprehensive and up-to-date and a prominent notice on the front page of the periodical advises readers that the issue contains an insert with important information about rights under the plan and the Act which should be read and retained for future reference. If some participants and beneficiaries are not on the mailing list, a periodical must be used in conjunction with other methods of distribution such that the methods taken together are reasonably calculated to ensure actual receipt. Material distributed through the mail may be sent by first, second, or third-class mail. However, distribution by second or third-class mail is acceptable only if return and forwarding postage is guaranteed and address correction is requested. Any material sent by second or third-class mail which is returned with an address correction shall be sent again by first-class mail or personally delivered to the participant at his or her worksite.

(2) For purposes of section 104(b)(4) of the Act, materials furnished upon written request shall be mailed to an address provided by the requesting participant or beneficiary or personally delivered to the participant or beneficiary.

(3) For purposes of section 104(b)(2) of the Act, where certain documents are required to be made available for examination by participants and beneficiaries in the principal office of the plan administrator and in such other places as may be necessary to make
available all pertinent information to all participants and beneficiaries, disclosure shall be made pursuant to the provisions of this paragraph. Such documents must be current, readily accessible, and clearly identified, and copies must be available in sufficient number to accommodate the expected volume of inquiries. Plan administrators shall make copies of the latest annual report, and the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available at all times in their principal offices. They are not required to maintain these plan documents at all times at each employer establishment or union hall or office as described in paragraphs (b)(3)(i), (ii), and (iii) of this section, but the documents must be made available at any such location within ten calendar days following the day on which a request for disclosure at that location is made. Plan administrators shall make plan documents available at the appropriate employer establishment or union meeting hall or office within the required ten day period when a request is made directly to the plan administrator or through a procedure establishing reasonable rules for examination of plan documents. If a plan administrator prescribes such a procedure and communicates it to plan participants and beneficiaries, a plan administrator will not be required to comply with a request made in a manner which does not conform to the established procedure. In order to comply with the requirements of this section, a procedure for making requests to examine plan documents must permit requests to be made in a reasonably convenient manner both directly to the plan administrator and at each employer establishment, or union meeting hall or office where documents must be made available in accordance with this paragraph. If no such reasonable procedure is established, a good faith effort by a participant or beneficiary to request examination of plan documents will be deemed a request to the plan administrator for purposes of this paragraph.

(i) In the case of a plan not maintained according to a collective bargaining agreement, including a plan maintained by a single employer with more than one establishment, a multiple employer plan, and a plan maintained by a controlled group of corporations (within the meaning of section 1563(a) of the Internal Revenue Code of 1984 (the Code)), determined without regard to section 1563(a)(4) and (e)(3)(C) of the Code), documents shall be made available for examination in the principal office of the employer and at each employer establishment in which at least 50 participants covered under a plan are customarily working. "Establishment" means a single physical location where business is conducted or where services or industrial operations are performed. Where employees are engaged in activities which are physically dispersed, such as agriculture, construction, transportation and communications, the "establishment" shall be the place to which employees report each day. When employees do not usually work at, or report to, a single establishment—for example, traveling salesmen, technicians, and engineers—the establishment shall be the location from which the employees customarily carry out their activities—for example the field office of an engineering firm servicing at least 50 participants covered under the plan.

(ii) In the case of a plan maintained solely by an employee organization, the plan administrator shall take measures to ensure that documents are available for examination at the meeting hall or office of each union local in which there are at least 50 participants covered under the plan. Such measures shall include distributing copies of the documents to each union local in which there are at least 50 participants covered under the plan.

(iii) In the case of a plan maintained according to a collective bargaining agreement, including a collectively bargained single employer plan with more than one establishment, a collectively bargained multiple employer plan, and a multiemployer plan which meets the definition of section 3(37) of the Act, §2510.3–37 of this chapter, and section 414(b) of the Internal Revenue Code of 1954 and 26 CFR 1.414(f) (40 FR 43034), documents shall be made available for examination in the principal
office of the employee organization and at each employer establishment in which at least 50 participants covered under the plan are customarily working. In employment situations where employees do not usually work at, or report to, a single establishment, the plan administrator shall take measures to ensure that plan documents are available for examination at the meeting hall or office of each union local in which there are at least 50 participants covered under the plan.

(c) Disclosure through electronic media.

(1) Except as otherwise provided by applicable law, rule or regulation, the administrator of an employee benefit plan furnishing documents through electronic media is deemed to satisfy the requirements of paragraph (b)(1) of this section with respect to an individual described in paragraph (c)(2) if:

(A) Results in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information); and

(B) Protects the confidentiality of personal information relating to the individual’s accounts and benefits (e.g., incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

(ii) The electronically delivered documents are prepared and furnished in a manner that is consistent with the style, format and content requirements applicable to the particular document;

(iii) Notice is provided to each participant, beneficiary or other individual, in electronic or non-electronic form, at the time a document is furnished electronically, that apprises the individual of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes changes in the benefits provided by your plan) and of the right to request and obtain a paper version of such document; and

(iv) Upon request, the participant, beneficiary or other individual is furnished a paper version of the electronically furnished documents.

(2) Paragraph (c)(1) shall only apply with respect to the following individuals:

(i) A participant who—

(A) Has the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform his or her duties as an employee; and

(B) With respect to whom access to the employer’s or plan sponsor’s electronic information system is an integral part of those duties; or

(ii) A participant, beneficiary or any other person entitled to documents under Title I of the Act or regulations issued thereunder (including, but not limited to, an “alternate payee” within the meaning of section 206(d)(3) of the Act and a “qualified beneficiary” within the meaning of section 607(3) of the Act) who—

(A) Except as provided in paragraph (c)(2)(ii)(B) of this section, has affirmatively consented, in electronic or non-electronic form, to receiving documents through electronic media and has not withdrawn such consent;

(B) In the case of documents to be furnished through the Internet or other electronic communication network, has affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates the individual’s ability to access information in the electronic form that will be used to provide the information that is the subject of the consent, and has provided an address for the receipt of electronically furnished documents;

(C) Prior to consenting, is provided, in electronic or non-electronic form, a clear and conspicuous statement indicating:

(1) The types of documents to which the consent would apply;

(2) That consent can be withdrawn at any time without charge;

(3) The procedures for withdrawing consent and for updating the participant’s, beneficiary’s or other individual’s address for receipt of electronically furnished documents or other information;
(4) The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and

(5) Any hardware and software requirements for accessing and retaining the documents; and

(D) Following consent, if a change in hardware or software requirements needed to access or retain electronic documents creates a material risk that the individual will be unable to access or retain electronically furnished documents:

(1) Is provided with a statement of the revised hardware or software requirements for access to and retention of electronically furnished documents;

(2) Is given the right to withdraw consent without charge and without the imposition of any condition or consequence that was not disclosed at the time of the initial consent; and

(3) Again consents, in accordance with the requirements of paragraph (c)(2)(ii)(A) or paragraph (c)(2)(ii)(B) of this section, as applicable, to the receipt of documents through electronic media.

(d) Participant and beneficiary status for purposes of section 101(a) and 104(b)(1) of the Act and subpart F of this part. See §§ 2510.3–3(d) and 2520.3–3(d) of this chapter, as applicable, to the receipt of documents through electronic media.

(ii) Examples: Company A is negotiating the purchase of Company B. On September 1, 1978, as part of the negotiations, Company A adopts a pension plan covering the employees of Company B, contingent on the successful conclusion of its negotiations to purchase Company B. The plan provides that it shall take effect on the first day of the calendar year in which the purchase is concluded. On February 1, 1979, the negotiations conclude with Company A’s purchase of Company B. The plan therefore becomes effective on February 1, 1979, retroactive to January 1, 1979. The summary plan description must be filed and disclosed no later than 120 days after February 1, 1979.
§ 2520.104b–3  29 CFR Ch. XXV (7–1–15 Edition)

(b) Periods for furnishing updated summary plan description. (1) For purposes of the requirement to furnish the updated summary plan description to each participant and each beneficiary receiving benefits under the plan (other than beneficiaries receiving benefits under a welfare plan) required by section 104(b)(1) of the Act, the administrator of an employee benefit plan shall furnish such updated summary plan description no later than 210 days following the end of the plan year which occurs five years after the last date a change in the information required to be disclosed by section 102 or 29 CFR 2520.102–3 would have been reflected in the most recently distributed summary plan description (or updated summary plan description) as described in section 102 of the Act.

(2) In the case of a plan to which no amendments have been made between the end of the time period covered by the last distributed summary plan description (or updated summary plan description) described in section 102 of the Act, and the next occurring applicable date described in paragraph (b)(1) of this section, for purposes of the requirement to furnish the updated summary plan description to each participant, and to each beneficiary receiving benefits under the plan (other than beneficiaries receiving benefits under a welfare plan), required by section 104(b)(1) of the Act, the administrator of an employee benefit plan shall furnish such updated summary plan description no later than 210 days following the end of the plan year which occurs ten years after the last date a change in the information described in section 102 of the Act would have been reflected in the most recently distributed summary plan description (or updated summary plan description), described in section 102 of the Act, and the next occurring applicable date described in paragraph (b)(1) of this section.

(g) Terminated plans. (1) If on or before the date by which a plan is required to furnish a summary plan description or updated summary plan description to participants and pension plan beneficiaries under this section, the plan has terminated within the meaning of paragraph (g)(2) of this section, the administrator of such plan is not required to furnish to participants covered under the plan or to beneficiaries receiving benefits under the plan a summary plan description.

(h) [Reserved]

(i) Style and format of the summary plan description. See § 2520.102–2.

(j) Contents of the summary plan description. See § 2520.102–3.

(k) Option for different summary plan descriptions. See § 2520.102–4; § 2520.104–26; and § 2520.104–27.

(l) Employee benefit plan—participant covered under a plan. See § 2510.3–3(d).

adopted. This disclosure date is not affected by retroactive application to a prior plan year of an amendment which makes a material modification to the plan; a modification does not occur before it is adopted. For example, a calendar year plan adopts a modification in April, 1978. The modification, by its terms, applies retroactively to the 1977 plan year. A summary description of the material modification is furnished on or before July 29, 1979. A plan which adopts an amendment which makes a material modification to the plan which takes effect on a date in the future must disclose a summary of that modification within 210 days after the close of the plan year in which the modification or change is adopted. Under the authority of sections 104(a)(3) and 110 of the Act, a summary description of a material modification or change is not required to be disclosed if it is rescinded or otherwise does not take effect. For example, a calendar year plan adopts a modification in June, 1978. The modification, by its terms, becomes effective beginning in plan year 1979. Before the beginning of plan year 1979, the prospective modification is withdrawn. No summary of the material modification is required to be disclosed.

(b) The summary of material modifications to the plan or changes in information required to be included in the summary plan description need not be furnished separately if the changes or modifications are described in a timely summary plan description. For example, a calendar year plan adopts a material modification on June 3, 1976. The modification is incorporated in a summary plan description furnished on July 15, 1977. No separate summary of the material modification is furnished. The plan adopts another material modification September 15, 1977. A separate summary of the modification is furnished on or before July 29, 1978.

(c) The copy of the summary plan description furnished in accordance with §§2520.104b–2(a)(1)(i) and 2520.104b–4 shall be accompanied by all summaries of material modifications or changes in information required to be included in the summary plan description which have not been incorporated into that summary plan description.

(d) Special rule for group health plans—

(1) General. Except as provided in paragraph (d)(2) of this section, the administrator of a group health plan, as defined in section 733(a)(1) of the Act, shall furnish to each participant covered under the plan a summary, written in a manner calculated to be understood by the average plan participant, of any modification to the plan or change in the information required to be included in the summary plan description, within the meaning of paragraph (a) of this section, that is a material reduction in covered services or benefits not later than 60 days after the date of adoption of the modification or change.

(2) 90-day alternative rule. The administrator of a group health plan shall not be required to furnish a summary of any material reduction in covered services or benefits within the 60-day period described in paragraph (d)(1) of this section to any participant covered under the plan who would reasonably be expected to be furnished such summary in connection with a system of communication maintained by the plan sponsor or administrator, with respect to which plan participants are provided information concerning their plan, including modifications and changes thereto, at regular intervals of not more than 90 days and such communication otherwise meets the disclosure requirements of 29 CFR 2520.104b–1.

(3) “Material reduction.” (i) For purposes of this paragraph (d), a “material reduction in covered services or benefits” means any modification to the plan or change in the information required to be included in the summary plan description that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average plan participant to be an important reduction in covered services or benefits under the plan.

(ii) A “reduction in covered services or benefits” generally would include any plan modification or change that: eliminates benefits payable under the plan; reduces benefits payable under the plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that
serve as the basis for making benefit determinations; increases premiums, deductibles, coinsurance, copayments, or other amounts to be paid by a participant or beneficiary; reduces the service area covered by a health maintenance organization; establishes new conditioning requirements (e.g., preauthorization requirements) to obtaining services or benefits under the plan.

(e) Applicability date. Paragraph (d) of this section is applicable as of the first day of the first plan year beginning after June 30, 1997.

(f)–(g) [Reserved]

(Approved by the Office of Management and Budget under control number 1210-0039)


§ 2520.104b–4 Alternative methods of compliance for furnishing the summary plan description and summaries of material modifications of a pension plan to a retired participant, a separated participant with vested benefits, and a beneficiary receiving benefits.

Under the authority of section 110 of the Act, in the case of an employee pension benefit plan—

(a) Summary plan descriptions. A plan administrator will be deemed to satisfy the requirements of section 104(b)(1) of the Act and § 2520.104b–2(a) to furnish a copy of the initial summary plan description to a retired participant, a beneficiary receiving benefits, or a separated participant with vested benefits (“vested separated participant”) if, no earlier than the date stated in paragraph (a)(4) of this section—

(i) In the case of a retired participant or a beneficiary receiving benefits, a document is furnished which—

(1) Meets the requirements of §§ 2530.102–2 and 2530.102–3 except paragraphs (b)(3), (b)(4), (j), (l), (n), (o), (p) and (q);

(ii) Contains a statement that the benefit payment presently being received by the retired participant or beneficiary receiving benefits will continue in the same amount and for the period provided in the mode of settlement selected at retirement, and will not be changed except as described in paragraph (a)(1)(iii) of this section; and

(iii) Contains a statement describing any plan provision under which the present benefit payment may be reduced, changed, terminated, forfeited or suspended;

(2) In the case of a vested separated participant, a document is furnished which—

(i) Meets the requirements of §§ 2530.102–2 and 2530.102–3 except paragraphs (b)(3), (b)(4), (j), (l), (n), (o), (p) and (q);

(ii)(A) If at or after separation, a separated vested participant was furnished a statement of the dollar amount of the vested benefit or the method of computation of the benefit, includes a statement that the dollar amount of the vested benefit was previously furnished and that a copy of the previously furnished statement of the dollar amount of such vested benefit or method of computation of the benefit may be obtained from the plan upon request;

(B) If the vested separated participant was not furnished a statement of the dollar amount of the vested benefit or the method of computation of the benefit, the plan furnishes either a statement of the dollar amount of the vested benefit, or a statement of the formula used to determine the dollar amount of the vested benefit;

(iii) Includes a statement of the form in which the benefits will be paid and duration of the payment period or a description of the optional modes of payment available under the plan; and

(iv) Includes a statement describing any plan provision under which a benefit may be reduced, changed, terminated, forfeited or suspended; or

(3)(i) Such retired participant, vested separated participant, or beneficiary receiving benefits was furnished with a copy of a document which—

(A) Satisfies the requirements of section 102(a)(1) of the Act and § 2520.102–2 (relating to the style and format of the summary plan description) and § 2520.102–3 (relating to the content of the summary plan description);

(B) Describes the rights and obligations under the plan of such retired participant, vested separated participant, or beneficiary receiving benefits...
as of the date stated in subparagraph (4):

(ii) In the case of a person who retired, became a beneficiary, or separated with vested benefits before November 16, 1977, a document will be deemed to comply with the requirements of paragraph (a)(2)(i) of this section if the document omitted only information described in one or more of the provisions of §2520.102–3 listed below, provided that a supplement containing such information, which meets the requirements of §2520.102–2, is furnished to the retired participant, vested separated participant, or beneficiary receiving benefits by November 16, 1977.

(A) Employer identification number (EIN), as required by §2520.102–3(c);

(B) Type of administration, as required by §2520.102–3(e);

(C) Name of agent for service of legal process, as required by §2520.102–3(g);

(D) Names and addresses of trustees, as required by §2520.102–3(h);

(E) Statement regarding plan termination insurance as required by §2520.102–3(m);

(F) Date of the end of the fiscal year, as required by §2520.102–3(r); or

(G) Statement of ERISA rights, as required by §2520.102–3(t).

(4) For purposes of this paragraph the dates are:

(a) For a vested separated participant, the date of separation; for a beneficiary, the date on which payment of benefits commences; and for a retired participant, the date of retirement.

(b) Updated summary plan descriptions.

A copy of an updated summary plan description need not be furnished as prescribed in section 104(b)(1) of the Act and §2520.104b–2(b) to a retired participant, vested separated participant, or beneficiary receiving benefits if—

(1)(i) On or after the date stated in paragraph (b)(1)(ii) of this section, the retired participant, vested separated participant, or beneficiary is furnished with a copy of the most recent summary plan description and a copy of any summaries of material modifications not incorporated in such summary plan description;

(ii) For purposes of paragraph (b)(1)(i) of this section the dates are: for a retired participant, the date of retirement; for a vested separated participant, the date on which payment of benefits commences; and for a beneficiary, the date on which payment of benefits commences;

(2) No later than the date on which an updated summary plan description is furnished to participants and beneficiaries as prescribed by section 104(b)(1) of the Act and §2520.104b–2(b), a retired participant, vested separated participant, or beneficiary receiving benefits is furnished a notice containing the following:

(i) A statement that the benefit rights of such retired participant, vested separated participant, or beneficiary receiving benefits are set forth in the earlier summary plan description and any subsequently furnished summaries of material modifications (see paragraph (c)), and

(ii) A statement that such retired participant, vested separated participant, or beneficiary receiving benefits may obtain a copy of the earlier summary plan description and summaries of material modifications described in paragraph (b)(2)(i) of this section, and the updated summary plan description, without charge, upon request, from the plan administrator; and

(3) The plan administrator furnishes a copy of the documents described in paragraph (b)(2)(i) of this section to such retired participant, vested separated participant or beneficiary, without charge, upon request.

(c) Summary of material modifications or changes.

A summary description of a material modification to the plan or a change in the information required to be included in the summary plan description need not be furnished to a retired participant, a vested separated participant or a beneficiary receiving benefits, if the material modification or change in no way affects such retired participant’s, vested separated participant’s, or beneficiary’s rights under the plan. For example, a change in trustees is information which such a person may need to know in order to make inquiries about his or her rights expeditiously, and hence must be furnished. On the other hand, a modification in benefits under
the plan to which such retired participant, vested separated participant, or beneficiary had not at any time been entitled (and would not in the future be entitled) would not affect his or her rights and hence need not be furnished. If such retired participant, vested separated participant, or beneficiary requests a copy of a summary description of a material modification or a change which was not furnished, the plan administrator shall furnish the copy, without charge.

[45 FR 14032, Mar. 4, 1980, as amended at 61 FR 33850, July 1, 1996]

§ 2520.104b–10 Summary Annual Report.

(a) Obligation to furnish. Except as otherwise provided in paragraph (g) of this section, the administrator of any employee benefit plan shall furnish annually to each participant of such plan and to each beneficiary receiving benefits under such plan (other than beneficiaries under a welfare plan) a summary annual report conforming to the requirements of this section. Such furnishing of the summary annual report shall take place in accordance with the requirements of §2520.104b–1 of this part.

(b) [Reserved]

(c) When to furnish. Except as otherwise provided in this paragraph (c), the summary annual report required by paragraph (a) of this section shall be furnished within nine months after the close of the plan year.

(1) In the case of a welfare plan described in §2520.104–43 of this part, such furnishing shall take place within 9 months after the close of the fiscal year of the trust or other entity which files the annual report under §2520.104a–6 of this part.

(2) When an extension of time in which to file an annual report has been granted by the Internal Revenue Service, such furnishing shall take place within 2 months after the close of the period for which the extension was granted.

(d) Contents, style and format. Except as otherwise provided in this paragraph (d), the summary annual report furnished to participants and beneficiaries of an employee pension benefit plan pursuant to this section shall consist of a completed copy of the form prescribed in paragraph (d)(3) of this section, and the summary annual report furnished to participants and beneficiaries of an employee welfare benefit plan pursuant to this section shall consist of a completed copy of the form prescribed in paragraph (d)(4) of this section. The information used to complete the form shall be based upon information contained in the most recent annual report of the plan which is required to be filed in accordance with section 104(a)(1) of the Act.

(1) Any portion of the forms set forth in this paragraph (d) which is not applicable to the plan to which the summary annual report relates, or which would require information which is not required to be reported on the annual report of that plan, may be omitted.

(2) Where the plan administrator determines that additional explanation of any information furnished pursuant to this paragraph (d) is necessary to fairly summarize the annual report, such explanation shall be set forth following the completed form required by this paragraph (d) and shall be headed, “Additional Explanation.”

(3) Form for Summary Annual Report Relating to Pension Plans.

SUMMARY ANNUAL REPORT FOR (NAME OF PLAN)

This is a summary of the annual report for (name of plan and EIN) for (period covered by this report). The annual report has been filed with the Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Financial Statement

Benefits under the plan are provided by (indicate funding arrangements). Plan expenses were ($ ). These expenses included ($ ) in administrative expenses and ($ ) in benefits paid to participants and beneficiaries, and ($ ) in other expenses. A total of ( ) persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

[If the plan is funded other than solely by allocated insurance contracts:]

The value of plan assets, after subtracting liabilities of the plan, was ($ ) as of (the end of the plan year), compared to ($ ) as of (the beginning of the plan year). During
the plan year the plan experienced an (increase) (decrease) in its net assets of ($ ). This (increase) (decrease) includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan’s assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of ($ ), including employer contributions of ($ ), employee contributions of ($ ), (gains) (losses) of ($ ), from the sale of assets, and earnings from investments of ($ ).

[If any funds are used to purchase allocated insurance contracts:]

The plan has (a) contract(s) with (name of insurance carrier(s)) which allocate(s) funds or other obligations whether individual policies, group deferred annuities or other. The total premiums paid for the plan year ending (date) were ($ ).

**Minimum Funding Standards**

[If the plan is a defined benefit plan:]

An actuary’s statement shows that (enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA) (not enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA). The amount of the deficit was ($ ).

[If the plan is a defined contribution plan covered by funding requirements:]

(Enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA) (Not enough money was contributed to the plan to keep it funded in accordance with the minimum funding standards of ERISA). The amount of the deficit was ($ ).

**Your Rights to Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, write or call the office of (name), who is (state title: e.g., the plan administrator), (business address and telephone number). The charge to cover copying costs will be ($ ) for the full annual report, or ($ ) per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge. You also have the legally protected right to examine the annual report at the main office of the plan (at address), (at any other location where the report is available for examination), and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N–1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.


**SUMMARY ANNUAL REPORT FOR (NAME OF PLAN)**

This is a summary of the annual report of the (name of plan, EIN and type of welfare plan) for (period covered by this report). The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

[If any benefits under the plan are provided on an uninsured basis:]

(Name of sponsor) has committed itself to pay (all, certain) (state type of) claims incurred under the terms of the plan.

[If any of the funds are used to purchase insurance contracts:]

555
**Insurance Information**

The plan has (a) contract(s) with (name of insurance carrier(s)) to pay (all, certain) (state type of) claims incurred under the terms of the plan. The total premiums paid for the plan year ending (date) were ($ ).

([If applicable add:] Because (it is a) (they are) so called “experience-rated” contract(s), the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending (date), the premiums paid under such “experience-rated” contract(s) were ($ ) and the total of all benefit claims paid under these experience-rated contract(s) during the plan year was ($ ).

([If any funds of the plan are held in trust or in a separately maintained fund:]）

**Basic financial statement**

The value of plan assets, after subtracting liabilities of the plan, was ($ ) as of the end of plan year, compared to ($ ) as of the beginning of the plan year. During the plan year the plan experienced an (increase) (decrease) in its net assets of ($ ). This (increase) (decrease) includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan’s assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of ($ ) including employer contributions of ($ ), employee contributions of ($ ), realized (gains) (losses) of ($ ) from the sale of assets, and earnings from investments of ($ ). Plan expenses were ($ ). These expenses included ($ ) in administrative expenses, ($ ) in benefits paid to participants and beneficiaries, and ($ ) in other expenses.

**Your Rights to Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report: [Note—list only those items which are actually included in the latest annual report].

1. an accountant’s report;
2. financial information and information on payments to service providers;
3. assets held for investment;
4. fiduciary information, including non-exempt transactions between the plan and parties-in-interest (that is, persons who have certain relationships with the plan);
5. loans or other obligations in default or classified as uncollectible;
6. leases in default or classified as uncollectible;
7. transactions in excess of 5 percent of the plan assets;
8. insurance information including sales commissions paid by insurance carriers; and
9. information regarding any common or collective trusts, pooled separate accounts, master trusts or 103–12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of (name), who is (state title: e.g., the plan administrator), (business address and telephone number). The charge to cover copying costs will be ($ ) for the full annual report, or ($ ) per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (address), (at any other location where the report is available for examination), and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N–1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

(e) Foreign languages. In the case of either—

1. A plan which covers fewer than 100 participants at the beginning of a plan year in which 25 percent or more of all plan participants are literate only in the same non-English language; or
2. A plan which covers 100 or more participants in which 500 or more participants or 10 percent or more of all plan participants, whichever is less, are literate only in the same non-English language—

The plan administrator for such plan shall provide these participants with an English-language summary annual report which prominently displays a notice, in the non-English language common to these participants, offering
them assistance. The assistance provided need not involve written materials, but shall be given in the non-English language common to these participants. The notice offering assistance shall clearly set forth any procedures participants must follow to obtain such assistance.

(f) Furnishing of additional documents to participants and beneficiaries. A plan administrator shall promptly comply with any request by a participant or beneficiary for additional documents made in accordance with the procedures or rights described in paragraph (d) of this section.

(g) Exemptions. Notwithstanding the provisions of this section, a summary annual report is not required to be furnished with respect to the following:

(1) A totally unfunded welfare plan described in 29 CFR 2520.104–44(b)(1)(1);
(2) A welfare plan which meets the requirements of 29 CFR 2520.104–20(b);
(3) An apprenticeship or other training plan which meets the requirements of 29 CFR 2520.104–22;
(4) A pension plan for selected employees which meets the requirements of 29 CFR 2520.104–23;
(5) A welfare plan for selected employees which meets the requirements of 29 CFR 2520.104–24;
(6) A day care center referred to in 29 CFR 2520.104–25;
(7) A dues financed welfare plan which meets the requirements of 29 CFR 2520.104–26;
(8) A dues financed pension plan which meets the requirements of 29 CFR 2520.104–27; and
(9) A plan to which title IV of the Act applies.

APPENDIX TO § 2520.104b–10—THE SUMMARY ANNUAL REPORT (SAR) UNDER ERISA: A CROSS-REFERENCE TO THE ANNUAL REPORT

<table>
<thead>
<tr>
<th>SAR item</th>
<th>Form 5500 large plan filer line items</th>
<th>Form 5500 small plan filer line items</th>
<th>Form 5500–SF filer line items</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. PENSION PLAN:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Funding arrangement</td>
<td>Form 5500–9a</td>
<td>Same</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>2. Total plan expenses</td>
<td>Sch. H–2j</td>
<td>Sch. I–2j</td>
<td>Line 8h</td>
</tr>
<tr>
<td>3. Administrative expenses</td>
<td>Sch. H–2i(9)</td>
<td>Sch. I–2h</td>
<td>Line 8f</td>
</tr>
<tr>
<td>5. Other expenses</td>
<td>Sch. H–Subtract the sum of 2e(4) &amp; 2i(5) from 2j.</td>
<td>Sch. I–2i</td>
<td>Line 8g</td>
</tr>
<tr>
<td>6. Total participants</td>
<td>Form 5500–6f</td>
<td>Same</td>
<td>Line 5b</td>
</tr>
<tr>
<td>7. Value of plan assets (net):</td>
<td>Sch. H–1l [Col. (b)]</td>
<td>Sch. I–1c [Col. (b)]</td>
<td>Line 7c [Col. (b)].</td>
</tr>
<tr>
<td>a. End of plan year.</td>
<td>Sch. H–1l [Col. (a)]</td>
<td>Sch. I–1c [Col. (a)]</td>
<td>Line 7c [Col. (a)].</td>
</tr>
<tr>
<td>b. Beginning of plan year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Change in net assets</td>
<td>Sch. H–Subtract 1l [Col. (a)] from 1l [Col. (b)].</td>
<td>Sch. I–Subtract 1c [Col. (a)] from Col. (b).</td>
<td>Line 7c–Subtract Col. (a) from Col. (b).</td>
</tr>
<tr>
<td>a. Employer contributions.</td>
<td>Sch. H–2d</td>
<td>Sch. I–2d</td>
<td>Line 8c</td>
</tr>
<tr>
<td>b. Employee contributions.</td>
<td>Sch. H–2a(1)(A) &amp; 2a(2) if applicable.</td>
<td>Sch. I–2a(1) &amp; 2b if applicable.</td>
<td>Line 8a(1) if applicable.</td>
</tr>
<tr>
<td>c. Gains (losses) from sale of assets.</td>
<td>Sch. H–2a(1)(B) &amp; 2a(2) if applicable.</td>
<td>Sch. I–2a(2) &amp; 2b if applicable.</td>
<td>Line 8a(2) &amp; 8a(3) if applicable.</td>
</tr>
<tr>
<td>d. Earnings from investments.</td>
<td>Sch. H–2b(4)(C)</td>
<td>Same</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>9. Total income</td>
<td>Sch. H–Subtract the sum of 2a(3), 2b(4)(C) and 2c from 2d.</td>
<td>Sch. I–2c</td>
<td>Line 8b</td>
</tr>
<tr>
<td>10. Total insurance premiums.</td>
<td>Total of all Schs. A–6b</td>
<td>Total of all Schs. A–6b</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>11. Unpaid minimum required contribution (S–E plans) or Funding deficiency (ME plans):</td>
<td>Sch. SB–39</td>
<td>Same</td>
<td>Same.</td>
</tr>
<tr>
<td>a. S–E Defined benefit plans.</td>
<td>Sch. MB–10</td>
<td>Same</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>b. ME Defined benefit plans.</td>
<td>Sch. R–6c, if more than zero.</td>
<td>Same</td>
<td>Line 12d.</td>
</tr>
<tr>
<td>c. Defined contribution plans.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. WELFARE PLAN</td>
<td>All Schs. A–1(a)</td>
<td>Same</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>
### § 2520.104b–30 Charges for documents.

(a) **Application.** The plan administrator of an employee benefit plan may impose a reasonable charge to cover the cost of furnishing to participants and beneficiaries upon their written request, as required under section 104(b)(4) of the Act, copies of the following information, statements or documents: The latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. Except where explicitly permitted under the Act, no charge may be assessed for furnishing information, statements or documents as required by other provisions of the Act, which include, in part 1 of title I, sections 104(b)(1), (2), (3) and (c) and 105(a) and (c).

(b) **Reasonableness.** The charge assessed by the plan administrator to cover the costs of furnishing documents is reasonable if it is equal to the actual cost per page to the plan for the least expensive means of acceptable reproduction, but in no event may such charge exceed 25 cents per page. For example, if a plan printed a large number of pamphlets at $1.00 per 50-page pamphlet, the actual cost of reproduction for the entire pamphlet ($1.00) would be equal to 2 cents per page. If only one page of such a pamphlet were requested and each page cost 20 cents to be reproduced, the actual cost of providing those pages would be $1.20. In such a case, if a

<table>
<thead>
<tr>
<th>SAR item</th>
<th>Form 5500 large plan filer items</th>
<th>Form 5500 small plan filer items</th>
<th>Form 5500–SF filer line items</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Total (experience rated and non-experienced rated) insurance premiums.</td>
<td>All Schs. A–Sum of 9a(1) and 10a.</td>
<td>Same ..........................</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>4. Experience rated claims.</td>
<td>All Schs. A–9b(4)</td>
<td>Same ..........................</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>5. Value of plan assets (net): a. End of plan year.</td>
<td>Sch. H–1l [Col. (a)]</td>
<td>Sch. I–1c [Col. (a)]</td>
<td>Line 7c [Col. (a)].</td>
</tr>
<tr>
<td>6. Change in net assets.</td>
<td>Sch. H–Subtract 1l [Col. (a)] from 1l [Col. (b)].</td>
<td>Sch. I–Subtract 1c [Col. (a)] from 1c [Col. (b)].</td>
<td>Line 7c–Subtract [Col. (a)] from 7c [Col. (b)].</td>
</tr>
<tr>
<td>a. Employer contributions.</td>
<td>Sch. H–Subtract the sum of 2a(1), 2a(2) &amp; 2a(4) if applicable.</td>
<td>Sch. I–2a(2) &amp; 2b if applicable.</td>
<td>Line 8a(1) if applicable.</td>
</tr>
<tr>
<td>b. Employee contributions.</td>
<td>Sch. H–Subtract the sum of 2a(1), 2a(2) &amp; 2a(4) if applicable.</td>
<td>Sch. I–2a(2) &amp; 2b if applicable.</td>
<td>Line 8a(2) if applicable.</td>
</tr>
<tr>
<td>c. Gains (losses) from sale of assets.</td>
<td>Sch. H–Subtract 1l [Col. (a)] from 1l [Col. (b)].</td>
<td>Sch. I–Subtract 1c [Col. (a)] from 1c [Col. (b)].</td>
<td>Line 7c–Subtract [Col. (a)] from 7c [Col. (b)].</td>
</tr>
<tr>
<td>d. Earnings from investments.</td>
<td>Sch. H–Subtract the sum of 2a(1), 2a(2) &amp; 2a(4) if applicable.</td>
<td>Sch. I–2d ............................</td>
<td>Line 8b.</td>
</tr>
<tr>
<td>11. Other expenses.</td>
<td>Sch. H–Subtract the sum of 2a(1), 2a(2) &amp; 2a(4) if applicable.</td>
<td>Sch. I–2i ............................</td>
<td>Line 8g.</td>
</tr>
</tbody>
</table>

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

(a) Scope and purpose. Sections 107 and 209 of the Employee Retirement Income Security Act of 1974, as amended (ERISA), contain certain requirements relating to the maintenance of records for reporting and disclosure purposes and for determining the pension benefits to which participants and beneficiaries are or may become entitled. This section provides standards applicable to both pension and welfare plans concerning the use of electronic media for the maintenance and retention of records required to be kept under sections 107 and 209 of ERISA.

(b) General requirements. The record maintenance and retention requirements of sections 107 and 209 of ERISA are satisfied when using electronic media if:

(1) The electronic recordkeeping system has reasonable controls to ensure the integrity, accuracy, authenticity and reliability of the records kept in electronic form;

(2) The electronic records are maintained in a safe and accessible place, and in such manner as they may be readily inspected or examined (for example, the recordkeeping system should be capable of indexing, retaining, preserving, retrieving and reproducing the electronic records);

(3) The electronic records are readily convertible into legible and readable paper copy as may be needed to satisfy reporting and disclosure requirements or any other obligation under Title I of ERISA;

(4) The electronic recordkeeping system is not subject, in whole or in part, to any agreement or restriction that would, directly or indirectly, compromise or limit a person’s ability to comply with any reporting and disclosure requirement or any other obligation under Title I of ERISA; and

(5) Adequate records management practices are established and implemented (for example, following procedures for labeling of electronically maintained or retained records, providing a secure storage environment, creating back-up electronic copies and selecting an off-site storage location, observing a quality assurance program evidenced by regular evaluations of the electronic recordkeeping system including periodic checks of electronically maintained or retained records, and retaining paper copies of records that cannot be clearly, accurately or completely transferred to an electronic recordkeeping system).

(c) Legibility and readability. All electronic records must exhibit a high degree of legibility and readability when displayed on a video display terminal or other method of electronic transmission and when reproduced in paper form. The term “legibility” means the observer must be able to identify all letters and numerals positively and quickly to the exclusion of all other letters or numerals. The term “readability” means that the observer must be able to recognize a group of letters or numerals as words or complete numbers.

(d) Disposal of original paper records. Original paper records may be disposed of any time after they are transferred to an electronic recordkeeping system that complies with the requirements of this section, except such original records may not be discarded if the electronic record would not constitute a duplicate or substitute record under the terms of the plan and applicable federal or state law.
SUBCHAPTER D—MINIMUM STANDARDS FOR EMPLOYEE PENSION BENEFIT PLANS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2530—RULES AND REGULATIONS FOR MINIMUM STANDARDS FOR EMPLOYEE PENSION BENEFIT PLANS

Subpart A—Scope and General Provisions

§ 2530.200a Scope.

(a) Part 2 of title I of the Employee Retirement Income Security Act of 1974 (hereinafter referred to as “the Act”) contains minimum standards that a plan which is an employee pension benefit plan within the meaning of section 3(2) of the Act and which is covered under part 2 must satisfy. (For a general explanation of the coverage of part 2, see § 2530.201–1.) Substantially identical requirements are imposed by subchapter D of chapter 1 of subtitle A of the Internal Revenue Code of 1954 (hereinafter referred to as “the Code”) for plans seeking qualification for certain tax benefits under the Code. In general, the Code provisions apply to “qualified” pension, profit-sharing, and stock bonus plans described in section 401(a) of the Code, annuity plans described in section 403(a) of the Code and bond purchase plans described in section 405(a) of the Code. The standards contained in title I of the Act apply generally to both “nonqualified” and “qualified” employee pension benefit plans. The standards contained in the Act, and the related Code provisions, are “minimum” standards. In general, more liberal plan provisions (in terms of the benefit to be derived by the employee) are not prohibited.

(b) For a definition of the term “employee pension benefit plan”, see section 3(2) of the Act and § 2510.3–2.

(c) For a statement of the coverage of part 2 of the Act, see sections 4 and 201...
§ 2530.200a–2 Treasury regulations for purposes of the Act.

Regulations prescribed by the Secretary of the Treasury or his delegate under sections 410 and 411 of the Code (relating to minimum standards for participation and vesting) shall apply for purposes of sections 202 through 204 of the Act. Thus, except for those provisions (such as the definition of an hour of service or a year of service) for which authority to prescribe regulations is specifically delegated to the Secretary of Labor, regulations prescribed by the Secretary of the Treasury shall also be used to implement the related provisions contained in the Act. Those regulations specify the credit that must be given to an employee for years of service and years of participation completed by the employee. The allocation of regulatory jurisdiction between the Secretary of Treasury or his delegate and the Secretary of Labor is governed by titles I through III of the Act. See section 3002 of the Act (88 Stat. 996).

§ 2530.200a–3 Labor regulations for purposes of the Internal Revenue Code of 1954.

The Secretary of Labor is specifically authorized to prescribe certain regulations (generally relating to hour of service, year of service, break in service, year of participation and special rules for seasonal and maritime industries) applicable to both title I of the Act and sections 410 and 411 of the Code. These regulations are contained in this subpart (A) and subpart B of this part (2530) and must be integrated with regulations prescribed by the Secretary of the Treasury or his delegate under sections 410 of the Code (relating to minimum participation standards), 411(a) of the Code (relating to minimum vesting standards) and 411(b) of the Code (relating to benefit accrual requirements). The allocation of regulatory jurisdiction between the Secretary of Labor and the Secretary of the Treasury or his delegate is governed by titles I through III of the Act. See section 3002 of the Act (88 Stat. 996).

§ 2530.200b–1 Computation periods.

(a) General. Under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code, an employee's statutory entitlements with regard to participation, vesting and benefit accrual are generally determined by reference to years of service and years of participation completed by the employee and one-year breaks in service incurred by the employee. The units used for determining an employee's credit towards statutory participation, vesting and benefit accrual entitlements are in turn defined in terms of the number of hours of service credited to the employee during a specified period—in general, a twelve-consecutive-month period—referred to herein as a “computation period”. A plan must designate eligibility computation periods pursuant to §2530.202–2 and vesting computation periods pursuant to §2530.203–2, and, under certain circumstances, a defined benefit plan must designate accrual computation periods pursuant to §2530.204–2. An employee who is credited with 1000 hours of service during an eligibility computation period must generally be credited with a year of service for purposes of section 202 of the Act and section 410 of the Code (relating to minimum participation standards). An employee who is credited with 1000 hours of service during a vesting computation period must generally be credited with a year of service for purposes of section 203 of the Act and 411(a) of the Code (relating to minimum vesting standards). An employee who completes 1000 hours of service during an accrual computation period must, under certain circumstances, be credited with at least a partial year of participation for purposes of section 204 of the Act and section 411(b) of the Code (relating to benefit accrual requirements). With respect to benefit accrual, however, the plan may not be required to credit an employee with a full year of participation and, therefore, full accrual for such year of participation unless the employee is credited with the number of hours of service or other permissible units of credit prescribed under the plan for crediting of a full year of participation (see §2530.204–2 (c) and (d)). It should be noted that under some of the
equivalencies which a plan may use under §2530.200b-3 to determine the number of units of service to be credited to an employee in a computation period, an employee must be credited with a year of service of partial year of participation if the employee is credited with a number of units of service which is less than 1000 in a computation period. See also §2530.200b-9, relating to elapsed time.

(b) Rules generally applicable to computation periods. In general, employment at the beginning or the end of an applicable computation period or on any particular date during the computation period is not determinative of whether the employee is credited with a year of service or a partial year of participation, or incurs a break in service, for the computation period. Rather, these determinations generally must be made solely with reference to the number of hours (or other units of service) which are credited to the employee during the applicable computation period. For example, an employee who is credited with 1000 hours of service during any portion of a vesting computation period must be credited with a year of service for that computation period regardless of whether the employee is employed by the employer on the first or the last day of the computation period. It should be noted, however, that in certain circumstances, a plan may provide that certain consequences follow from an employee’s failure to be employed on a particular date. For example, under section 202(a)(4) of the Act and section 410(a)(4) of the Code, a plan may provide that an individual otherwise entitled to commence participation in the plan on a specified date does not commence participation on that date if he or she was separated from the service before that date. Similarly, under section 204(b)(1) of the Act and section 411(b)(1) of the Code, a plan which is not a defined benefit plan is not subject to section 204(b)(1) and (b)(3) of the Act and section 411(b)(1) and (b)(3) of the Code. Such a plan, therefore, may provide that an individual who has been a participant in the plan, but who has separated from service before the date on which the employer’s contributions to the plan or forfeitures are allocated among participant’s accounts or before the last day of the vesting computation period, does not share in the allocation of such contributions or forfeitures even though the individual is credited with 1000 or more hours of service for the applicable vesting computation period. Under certain circumstances, however, such a plan provision may result in discrimination prohibited under section 401(a)(4) of the Code. See Revenue Ruling 76–250, I.R.B. 1976–27.

§ 2530.200b–2 Hour of service.

(a) General rule. An hour of service which must, as a minimum, be counted for the purposes of determining a year of service, a year of participation for benefit accrual, a break in service and employment commencement date (or reemployment commencement date) under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code, is an hour of service as defined in paragraphs (a)(1), (2) and (3) of this section. The employer may round up hours at the end of a computation period or more frequently.

(1) An hour of service is each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer during the applicable computation period. The employer may round up hours at the end of a computation period or more frequently.

(2) An hour of service is each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Notwithstanding the preceding sentence,

(i) No more than 501 hours of service are required to be credited under this paragraph (a)(2) to an employee on account of any single continuous period during which the employee performs no duties (whether or not such period occurs in a single computation period);

(ii) An hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed is not required to be credited to the employee if such payment is made or due under a plan maintained solely for the purpose of complying with applicable
workmen’s compensation, or unemployment compensation or disability insurance laws; and

(iii) Hours of service are not required to be credited for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

For purposes of this paragraph (a)(2), a payment shall be deemed to be made by or due from an employer regardless of whether such payment is made by or due from the employer directly, or indirectly through, among others, a trust fund, or insurer, to which the employer contributes or pays premiums and regardless of whether contributions made or due to the trust fund, insurer or other entity are for the benefit of particular employees or are on behalf of a group of employees in the aggregate.

(3) An hour of service is each hour for which back pay, irrespective of mitigation of damages, is either awarded or agreed to by the employer. The same hours of service shall not be credited both under paragraph (a)(1) or paragraph (a)(2), as the case may be, and under this paragraph (a)(3). Thus, for example, an employee who receives a back pay award following a determination that he or she was paid at an unlawful rate for hours of service previously credited will not be entitled to additional credit for the same hours of service. Crediting of hours of service for back pay awarded or agreed to with respect to periods described in paragraph (a)(2) of this section, shall be subject to the limitations set forth in that paragraph. For example, no more than 501 hours of service are required to be credited for payments of back pay, to the extent that such back pay is agreed to or awarded for a period of time during which an employee did not or would not have performed duties.

(b) Special rule for determining hours of service for reasons other than the performance of duties. In the case of a payment which is made or due on account of a period during which an employee performs no duties, and which results in the crediting of hours of service under paragraph (a)(2) of this section, or in the case of an award or agreement for back pay, to the extent that such award or agreement is made with respect to a period described in paragraph (a)(2) of this section, the number of hours of service to be credited shall be determined as follows:

1) Payments calculated on the basis of units of time. (i) Except as provided in paragraph (b)(3) of this section, in case of a payment made or due which is calculated on the basis of units of time, such as hours, days, weeks or months, the number of hours of service to be credited shall be the number of regularly scheduled working hours included in the units of time on the basis of which the payment is calculated. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of hours to be credited on the basis of a 40-hour workweek or an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classifications, reasonably defined. Thus, for example, a plan may not use a 40-hour workweek as a basis for calculating the number of hours of service to be credited for periods of paid absences for one employee while using an average based on hours worked over a representative period of time as a basis for such calculation for another, similarly situated employee.

(ii) Examples. The following examples illustrate the rules in paragraph (b)(1) of this section without regard to paragraphs (b)(2) and (3).

(A) Employee A was paid for 6 hours of sick leave at his normal hourly rate. The payment was therefore calculated on the basis of units of time (hours). A must, therefore, be credited with 6 hours of service for the 6 hours of sick leave.

(B) Employee B was paid his normal weekly salary for 2 weeks of vacation. The payment was therefore calculated on the basis of units of time (weeks). B is scheduled to work 37 1/2 hours per week (although from time to time working overtime), B must, therefore, be credited with 75 hours of service for the vacation (37 1/2 hours per week multiplied by 2 weeks).
(C) Employee C spent 3 weeks on a paid vacation. C’s salary is established at an annual rate but is paid on a bi-weekly basis. The amount of salary payments attributable to be paid vacation was calculated on the basis of units of time (weeks). C has no regular work schedule but works at least 50 hours per week. The plan provides for the calculation of hours of service to be credited to employees in C’s situation for periods of paid absences on the basis of a 40-hour workweek. C must, therefore, be credited with 120 hours of service for the vacation (3 weeks multiplied by 40 hours per week).

(D) Employee D spent 2 weeks on vacation, for which he was paid $150. Although D has no regular work schedule, the $150 payment was established on the assumption that an employee in D’s position works an average of 30 hours per week at a rate of $2.25 per hour. The payment of $150 was therefore calculated on the basis of units of time (weeks). The plan provides for the calculation of hours of service to be credited to employees in D’s situation for periods of paid absences on the basis of an average of 30 hours worked per week over a 6-month period. D must, therefore, be credited with 56 hours of service for the vacation (28 hours per week multiplied by 2 weeks).

(E) Employee E is regularly scheduled to work a 40-hour week. During a computation period E is incapacitated as a result of injury for a period of 11 weeks. Under the sick leave policy of E’s employer E is paid his normal weekly salary for the first 8 weeks of his incapacity. After 8 weeks the employer ceases to pay E’s normal salary but, under a disability insurance program maintained by the employer, E receives payments equal to 65% of his normal weekly salary for the remaining 3 weeks during which E is incapacitated. For the period during which he is incapacitated, therefore, E receives credit for 440 hours of service (11 weeks multiplied by 40 hours per week) regardless of the fact that payments to E for the last 3 weeks of the period during which he was incapacitated were made in amounts less than E’s normal compensation.

(2) Payments not calculated on the basis of units of time. (i) Except as provided in paragraph (b)(3) of this section, in the case of a payment made or due, which is not calculated on the basis of units of time, the number of hours of service to be credited shall be equal to the amount of the payment divided by the employee’s most recent hourly rate of compensation (as determined under paragraph (b)(2)(ii) of this section) before the period during which no duties are performed.

(ii) For purposes of paragraph (b)(2)(i) of this section an employee’s hourly rate of compensation shall be determined as follows:

(A) In the case of an employee whose compensation is determined on the basis of an hourly rate, such hourly rate shall be the employee’s most recent hourly rate of compensation.

(B) In the case of an employee whose compensation is determined on the basis of a fixed rate for specified periods of time (other than hours) such as days, weeks or months, the employee’s hourly rate of compensation shall be the employee’s most recent rate of compensation for a specified period of time (other than an hour), divided by the number of hours regularly scheduled for the performance of duties during such period of time. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, the plan may provide for the calculation of the employee’s hourly rate of compensation on the basis of a 40-hour workweek, an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classification, reasonably defined.

(C) In the case of an employee whose compensation is not determined on the basis of a fixed rate for specified periods of time, the employee’s hourly rate of compensation shall be the lowest hourly rate of compensation paid to employees in the same job classification as that of the employee or, if no
employees in the same job classification have an hourly rate, the minimum wage as established from time to time under section 6(a)(1) of the Fair Labor Standards Act of 1938, as amended.

(iii) Examples. The following examples illustrate the rules in paragraph (b)(2) of this section without regard to paragraphs (b)(1) and (3).

(A) As a result of an injury, an employee is incapacitated for 5 weeks. A lump sum payment of $500 is made to the employee with respect to the injury under a disability insurance plan maintained by the employee’s employer. At the time of the injury, the employee’s rate of pay was $3.00 per hour. The employee must, therefore, be credited with 167 hours of service ($500 divided by $3.00 per hour).

(B) Same facts as in Example (A), above, except that at the time of the injury, the employee’s rate of pay was $160 per week and the employee has a regular work schedule of 40 hours per week. The employee’s hourly rate of compensation is, therefore, $4.00 per hour ($160 per week divided by 40 hours per week) and the employee must be credited with 125 hours of service for the period of absence ($500 divided by $4.00 per hour).

(C) An employee is paid at an hourly rate of $3.00 per hour and works a regular schedule of 40 hours per week. The employee is disabled for 26 weeks during a computation period. For the first 12 weeks of disability, the employee is paid his normal weekly earnings of $120 per week by the employer. Thereupon, a lump-sum disability payment of $1000 is made to the employee under a disability insurance plan maintained by the employer. Under paragraph (a)(3)(i) of this section, the employee is credited with 501 hours of service for the period of disability (lesser of 501 hours—the maximum number of hours required to be credited for a period of absence—or the sum of 12 weeks multiplied by 40 hours per week plus $1000 divided by $3.00 per hour).

(3) Rule against double credit. (i) Notwithstanding paragraphs (b)(1) and (2) of this section, an employee is not required to be credited on account of a period during which no duties are performed with a number of hours of service which is greater than the number of hours regularly scheduled for the performance of duties during such period. For purposes of applying the preceding sentence in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of hours of service to be credited to the employee for a period during which no duties are performed on the basis of a 40-hour workweek or an 8-hour workday, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(ii) Examples. (A) Employee A has a regular 40-hour workweek. Each year Employee A is entitled to pay for a two-week vacation, in addition to receiving normal wages for all hours worked, regardless of whether A actually takes a vacation and regardless of the duration of his vacation. The vacation payments are, therefore, calculated on the basis of units of time (weeks). In computation period I, A takes no vacation but receives vacation pay. A is entitled to no credit for hours of service for the vacation payment made in computation period I because the payment was not made on account of a period during which no duties were performed. In computation period II, A takes a vacation of one week in duration, although receiving pay for a two-week vacation. A is entitled to be credited with 40 hours of service for his one-week vacation in computation period II even though paid for two weeks of vacation. In computation period III, A takes a vacation of one week in duration, although receiving pay for a two-week vacation. A is entitled to be credited with 40 hours of service for his one-week vacation in computation period III (40 hours per week multiplied by 2 weeks) even though the vacation lasted more than 2 weeks.

(B) Employee B has no regular work schedule. As a result of an injury, B is incapacitated for 1 day. A lump-sum payment of $500 is made to A with respect to the injury under an insurance program maintained by the employer.
A pension plan maintained by the employer provides for the calculation of the number of hours of service to be credited to an employee without a regular work schedule on the basis of an 8-hour day. A is therefore required to be credited with no more than 8 hours for the day during which he was incapacitated, even though A’s rate of pay immediately before the injury was $3.00 per hour.

(c) Crediting of hours of service to computation periods. (1) Except as provided in paragraph (c)(4) of this section, hours of service described in paragraph (a)(1) of this section shall be credited to the computation period in which the duties are performed.

(2) Except as provided in paragraph (c)(4) of this section, hours of service described in paragraph (a)(2) of this section shall be credited as follows:

(i) Hours of service credited to an employee on account of a payment which is calculated on the basis of units of time, such as hours, days, weeks or months, shall be credited to the computation period or computation periods in which the period during which no duties are performed occurs, beginning with the first unit of time to which the payment relates.

(ii) Hours of service credited to an employee by reason of a payment which is not calculated on the basis of units of time shall be credited to the computation period in which no duties are performed occurs, or if the period during which no duties are performed extends beyond one computation period, such hours of service shall be allocated between not more than the first two computation periods on any reasonable basis which is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(3) Except as provided in paragraph (c)(4) of this section, hours of service described in paragraph (a)(3) of this section shall be credited to the computation period or periods to which the award or agreement for back pay pertains, rather than to the computation period in which the award, agreement or payment is made.

(4) In the case of hours of service to be credited to an employee in connection with a period of no more than 31 days which extends beyond one computation period, all such hours of service may be credited to the first computation period or the second computation period. Crediting of hours of service under this paragraph must be done consistently with respect to all employees within the same job classifications, reasonably defined.

(5) Examples. The following examples are intended to illustrate paragraph (c)(4) of this section.

(i) An employer maintaining a plan pays employees on a bi-weekly basis. The plan designates the calendar year as the vesting computation period. The employer adopts the practice of crediting hours of service for the performance of duties during a bi-weekly payroll period to the vesting computation period in which the payroll period ends. Thus, when a payroll period ends on January 7, 1978, all hours of service to be credited to employees for the performance of duties during that payroll period are credited to the vesting computation period beginning on January 1, 1978. This practice is consistent with paragraph (c)(4) of this section, even though some hours of service credited to the computation period beginning on January 1, 1978, are attributable to duties performed during the previous vesting computation period.

(ii) An employer maintains a sick leave policy under which an employee is entitled to a certain number of hours of sick leave each year, on account of which the employee is paid his or her normal rate of compensation. An employee with a work schedule of 8 hours per day, 5 days per week, is sick from December 26, 1977 through January 4, 1978. Unless the plan adopts the alternative method for crediting service under paragraph (c)(4) of this section (illustrated in Example (iii), below) for the period of paid sick leave, the plan, pursuant to paragraph (c)(2)(i) of this section, must...
Employee Benefits Security Admin., Labor § 2530.200b-2

credit the employee with 40 hours of service in the 1977 vesting computation period (5 days multiplied by 8 hours per day) and 24 hours of service in the 1978 vesting computation period (3 days multiplied by 8 hours per day).

(iii) Same facts as in Example (ii), above, except that the plan adopts the practice of crediting hours of service for sick leave and other periods of compensated absences to the vesting computation period in which the employer’s bi-weekly payroll period ends. The employee returns to work on January 5, 1978 and works for 2 days. For the 2-week payroll period ending on January 8, 1978, the employee may be credited with 80 hours of service in the 1978 vesting computation period (64 hours of service for the paid sick leave and 16 hours of service for the 2 days during which duties were performed).

(d) Other Federal law. Nothing in this section shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States or any rule or regulation issued under any such law. Thus, for example, nothing in this section shall be construed as denying an employee credit for an “hour of service” if credit is required by separate Federal law. Furthermore, the nature and extent of such credit shall be determined under such law.

(e) Additional examples. (1) During a computation period, an employee was paid for working 38¾ hours a week for 45 weeks. During the remaining 7 weeks of the computation period the employee was not employed by this employer. The employee completed 1,721½ hours of service (45 weeks worked multiplied by 38¼ hours per week). The employer may also round up hours at the end of the computation period or more frequently. Thus, this employee could be credited with 1,722 hours of service (or, if the employer rounded up at the end of each week, 39 hours of service per week, resulting in credit for 1,755 hours of service).

(2) During a computation period, an employee was paid for a workweek of 40 hours per week for 40 weeks and, including overtime, for working 50 hours per week for 8 weeks. The employee completed 2,000 hours of service (40 weeks multiplied by 40 hours per week, plus 8 weeks worked multiplied by 50 hours per week).

(3) During a computation period an employee was paid for working 2 regularly scheduled 40-hour weeks and then became disabled. The employee was disabled through the remainder of the computation period and the following computation period. Throughout the period of disability, payments were made to the employee as follows: For the first month of the period of disability, the employer continued to pay the employee the employee's normal compensation at the same rate as before the disability occurred; thereafter, under the employer's disability insurance policy, payments were made to the employee in amounts equal to 80 percent of the employee's compensation before the disability. For the first computation period the employee is credited with 80 hours of service for the performance of duties (2 weeks multiplied by 40 hours per week) and 501 hours of service for the period of disability (the lesser of 501 hours of service or 50 weeks multiplied by 40 hours per week), or a total of 581 hours of service; for the second computation period the employee is credited with no hours of service because, under paragraph (a)(2)(i) of this section, the maximum of 501 hours of service has been credited for the period of disability in the first computation period.

(4) An employee has a regularly scheduled 5-day, 40-hour week. During a computation period the employee works for the first week, spends the second week on a paid vacation, returns to work for an hour and is then disabled for the remainder of the computation period. Payments under a disability plan maintained by the employer are made to the employee on account of the period of disability. The employee is credited with 582 hours of service (40 hours for the period of paid vacation; 41 hours for the performance of duties; 501 hours for the period of disability).

(5) Same facts as in Example (4), above, except that the employee's period of disability begins before the employee returns from vacation to the performance of duties. The employee is credited with only 541 hours of service,
§ 2530.200b–3 Determination of service to be credited to employees.

(a) General rule. For the purpose of determining the hours of service which must be credited to an employee for a computation period, a plan shall determine hours of service from records of hours worked and hours for which payment is made or due or shall use an equivalency permitted under paragraph (d), (e) or (f) of this section to determine hours of service. Any records may be used to determine hours of service to be credited to employees under a plan, even though such records are maintained for other purposes, provided that they accurately reflect the actual number of hours of service with which an employee is required to be credited under §2530.200b–2(a). Payroll records, for example, may provide sufficiently accurate data to serve as a basis for determining hours of service. If, however, existing records do not accurately reflect the actual number of hours of service with which an employee is entitled to be credited, a plan must either develop and maintain adequate records or use one of the permitted equivalencies. A plan may in any case credit hours of service under any method which results in the crediting of no less than the actual number of hours of service required to be credited under §2530.200b–2(a) to each employee in a computation period, even though such method may result in the crediting of hours of service in excess of the number of hours required to be credited under §2530.200b–2. A plan is not required to prescribe in its documents which records are to be used to determine hours of service.

(b) Determination of pre-effective date hours of service. To the extent that a plan is required to determine hours of service completed before the effective date of part 2 of title I of the Act (see section 211 of the Act), the plan may use whatever records may be reasonably accessible to it and may make whatever calculations are necessary to determine the approximate number of hours of service completed before such effective date. For example, if a plan or an employer maintaining the plan has, or has access to, only the records of compensation of employees for the period before the effective date, it may derive the pre-effective date hours of service by using the hourly rate for the period or the hours customarily worked. If accessible records are insufficient to make an approximation of the number of pre-effective date hours of service for a particular employee or group of employees, the plan may make a reasonable estimate of the hours of service completed by such employee or employees during the particular period. For example, if records are available with respect to some employees, the plan may estimate the hours of other employees in the same job classification based on these records. A plan may use any of the equivalencies permitted under this section, or the elapsed time method of crediting service permitted under this...
section, or the elapsed time method of crediting service permitted under §2530.200b–9, to determine hours of service completed before the effective date of part 2 of title I of the Act.

(c) Use of equivalencies for determining service to be credited to employees. (1) The equivalencies permitted under paragraphs (d), (e) and (f) of this section are methods of determining service to be credited to employees during computation periods which are alternatives to the general rule for determining hours of service set forth in paragraph (a) of this section. The equivalencies are designed to enable a plan to determine the amount of service to be credited to an employee in a computation period on the basis of records which do not accurately reflect the actual number of hours of service required to be credited to the employee under §2530.200b–2(a). However, the equivalencies may be used even if such records are maintained. Any equivalency used by a plan must be set forth in the document under which the plan is maintained.

(2) A plan may use different methods of crediting service, including equivalencies permitted under paragraphs (d), (e) and (f) of this section and the method of crediting service under the general rule set forth in §2530.200b–2(a), for different classifications of employees covered under the plan or for different purposes, provided that such classifications are reasonable and are consistently applied. Thus, for example, a plan may provide that part-time employees are credited under the general method of crediting service set forth in §2530.200b–2 and full-time employees are credited under a permissible equivalency. A classification, however, will not be deemed to be reasonable or consistently applied if such classification is designed with an intent to preclude an employee or employees from attaining statutory entitlement with respect to eligibility to participate, vesting or benefit accrual. For example, a classification applied so that any employee credited with less than 1,000 hours of service during a given 12-consecutive-month period would be considered part-time and subject to the general method of crediting service rather than an equivalency would not be reasonable.

(3) Notwithstanding paragraphs (c)(1) and (2) of this section, the use of a permissible equivalency for some, but not all, purposes or the use of a permissible equivalency for some, but not all, employees may, under certain circumstances, result in discrimination prohibited under section 401a of the Code, even though it is permitted under this section.

(d) Equivalencies based on working time—(1) Hours worked. A plan may determine service to be credited to an employee on the basis of hours worked, as defined in paragraph (d)(3)(i) of this section, if 870 hours worked are treated as equivalent to 1,000 hours of service and 435 hours worked are treated as equivalent to 500 hours of service.

(2) Regular time hours. A plan may determine service to be credited to an employee on the basis of regular time hours, as defined in paragraph (d)(3)(ii) of this section, if 750 regular time hours are treated as equivalent to 1,000 hours of service and 375 regular time hours are treated as equivalent to 500 hours of service.

(3) For purposes of this section:

(i) The term “hours worked” shall mean hours of service described in §2530.200b–2(a), and hours for which back pay, irrespective of mitigation of damages, is awarded or agreed to by an employer, to the extent that such award or agreement is intended to compensate an employee for periods during which the employee would have been engaged in the performance of duties for the employer.

(ii) The term “regular time hours” shall mean hours worked, except hours for which a premium rate is paid because such hours are in excess of the maximum workweek applicable to an employee under section 7(a) of the Fair Labor Standards Act of 1938, as amended, or because such hours are in excess of a bona fide standard workweek or workday.

(4) A plan determining service to be credited to an employee on the basis of hours worked or regular time hours shall credit hours worked or regular time hours, as the case may be, to computation periods in accordance with the rules for crediting hours of service.
to computation periods set forth in §2530.200b-2(c).

(5) Examples. (i) A defined benefit plan uses the equivalency based on hours worked permitted under paragraph (d)(1) of this section. The plan uses the same 12-consecutive-month period for the vesting and accrual computation periods. The plan credits a participant with each hour for which the participant is paid, or entitled to payment, for the performance of duties for the employer during a computation period (as well as each hour for which back pay is awarded or agreed to). During a vesting/accrual computation period Participant A is credited with 870 hours worked. A is credited with a year of service for purposes of vesting for the computation period and with at least a partial year of participation for purposes of accrual, as if A had been credited with 1000 hours of service during the computation period. During the same computation period Participant B is credited with 436 hours of service. B is not credited with a year of service for purposes of vesting or a partial year or participation for purposes of accrual for the computation period, but does not incur a one-year break in service for the computation period, as if B had been credited with 501 hours of service during the computation period.

(ii) A plan uses the equivalency based on regular time hours permitted under paragraph (d)(2) of this section. During a computation period a participant works 370 regular time hours and 20 overtime hours. The participant incurs a one-year break in service for the computation period because he has not been credited with 375 regular time hours in the computation period.

(d) Equivalencies based on periods of employment.

(e) Equivalencies based on periods of employment. (1) Except as provided in paragraphs (e)(4) and (6) of this section, a plan may determine the number of hours of service to be credited to employees in a computation period on the following bases:

(i) On the basis of days of employment, if an employee is credited with 10 hours of service for each day for which the employee would be required to be credited with at least one hour of service under §2530.200b-2;

(ii) On the basis of weeks of employment, if an employee is credited with 45 hours of service for each week for which the employee would be required to be credited with at least one hour of service under §2530.200b-2;

(iii) On the basis of semi-monthly payroll periods, if an employee is credited with 95 hours of service for each semi-monthly payroll period for which the employee would be required to be credited with at least one hour of service under §2530.200b-2; or

(iv) On the basis of months of employment, if an employee is credited with 190 hours of service for each month for which the employee would be required to be credited with at least one hour of service under §2530.200b-2.

(2) Except as provided in paragraphs (e)(4) and (6) of this section, a plan may determine the number of hours of service to be credited to employees in a computation period on the basis of shifts if an employee is credited with the number of hours included in a shift for each shift for which the employee would be required to be credited with at least one hour of service under §2530.200b-2. If a plan uses the equivalency based on shifts permitted under this paragraph, the times of the beginning and end of each shift used as a basis for the determination of service shall be set forth in a document referred to in the plan.

(e) Equivalencies based on periods of employment. (1) Except as provided in paragraphs (e)(4) and (6) of this section, a plan may determine the number of hours of service to be credited to employees in a computation period on the following bases:

(i) On the basis of days of employment, if an employee is credited with 10 hours of service for each day for which the employee would be required to be credited with at least one hour of service under §2530.200b-2;

(ii) On the basis of weeks of employment, if an employee is credited with 45 hours of service for each week for which the employee would be required to be credited with at least one hour of service under §2530.200b-2;

(iii) On the basis of semi-monthly payroll periods, if an employee is credited with 95 hours of service for each semi-monthly payroll period for which the employee would be required to be credited with at least one hour of service under §2530.200b-2; or

(iv) On the basis of months of employment, if an employee is credited with 190 hours of service for each month for which the employee would be required to be credited with at least one hour of service under §2530.200b-2.

(2) Exception as provided in paragraphs (e)(4) and (6) of this section, a plan may determine the number of hours of service to be credited to employees in a computation period on the basis of shifts if an employee is credited with the number of hours included in a shift for each shift for which the employee would be required to be credited with at least one hour of service under §2530.200b-2. If a plan uses the equivalency based on shifts permitted under this paragraph, the times of the beginning and end of each shift used as a basis for the determination of service shall be set forth in a document referred to in the plan.

(3) Examples. The following examples illustrate the application of paragraphs (e)(1) and (2) of this section:

(i) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee works for one hour on the first workday of a week and then takes leave without pay for the entire remainder of the week. The plan must credit the employee with 45 hours of service for the week.

(ii) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee spends two days of a week on vacation with pay. The plan must credit the employee with 45 hours of service for the week.

(iii) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee spends two days of a week on vacation with pay and the
remainder of the week on leave without pay. The plan must credit the employee with 45 hours of service for the week.

(iv) A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section. An employee spends the entire week on leave without pay. The plan is not required to credit the employee with any hours of service for the week because no payment was made to the employee for the week of leave and, therefore, under §2530.200b–2 no hours of service would be credited to the employee for the week of leave.

(v) The workday of an employer maintaining a plan is scheduled in shifts. Ordinarily, each shift is 6 hours in duration. At certain times, however, the employer schedules 8-hour shifts in order to meet increased demand. Such shifts are described in a collective bargaining agreement referred to in the plan documents. The plan must credit an employee with 6 hours of service for each 6-hour shift for which the employee would be credited with one hour of service under §2530.200b–2, and with 8 hours of service for each such 8-hour shift.

(vi) An employer’s workday is divided into three 8-hour shifts, each employee generally working 5 shifts per week. A plan maintained by the employer uses the equivalency based on shifts permitted under paragraph (e)(2) of this section. An employee is on vacation with pay for 2 weeks, during which, in the ordinary course of his work schedule, he would have worked 10 shifts. The employee must be credited with 80 hours of service for the vacation (10 shifts multiplied by 8 hours per shift).

(vii) An employer’s workday is divided into three 8-hour shifts, each employee generally working 1 shift per workday. A plan maintained by the employer uses the equivalency based on shifts permitted under paragraph (e)(2) of this section. On a certain day, an employee works his normal 8-hour shift and an hour during the following shift. In addition to 8 hours service for the first shift, the employee must be credited with 8 hours of service for the following shift, since he would be entitled to be credited with at least one hour of service for the second shift under §2530.200b–2.

(viii) A plan uses the equivalency based on days permitted under paragraph (e)(1)(i) of this section. During a computation period an employee spends 2 weeks on vacation with pay. In the ordinary course of the employee’s regular work schedule, the employee would be engaged in the performance of duties for 10 days during the 2-week vacation period. Under §2530.200b–2, the employee would be credited with 100 hours of service for the 2-week vacation (10 days multiplied by 10 hours of service per day).

(4) For purposes of this paragraph, in the case of a payment described in §2530.200b–2(b)(2) (relating to payments not calculated on the basis of units of time), a plan using an equivalency based on units of time permitted under this paragraph shall credit the employee with the number of hours of service determined under paragraph (2) of §2530.200b–2(b), and, to the extent applicable, paragraph (e)(3), containing the rule against double crediting, of §2530.200b–2(b). For example, if an employee with a regular work schedule of 40 hours per week paid at a rate of $3.00 per hour is incapacitated for a period of 4 weeks and receives a lump sum payment of $500 for his incapacity, the employee must be credited with 160 hours of service for the period of incapacity, regardless of whether the plan uses an equivalency permitted under this paragraph (see example at §2530.200b–2(b)(3)). If, however, the employee is incapacitated for only 3 weeks, under §2530.200b–2(b)(3) the employee is not required to be credited with more than 120 hours of service (lesser of 167 hours of service determined under the preceding sentence or 3 weeks multiplied by 40 hours per week).

(5) For purposes of this paragraph, in the case of a payment to an employee calculated on the basis of units of time which are greater than the periods of employment used by a plan as a basis
§ 2530.200b–3

29 CFR Ch. XXV (7–1–15 Edition)

for determining service to be credited to the employee under this paragraph, the plan shall credit the employee with the number of periods of employment which, in the course of the employee’s regular work schedule, would be included in the unit or units of time on the basis of which the payment is calculated. For example, a plan uses the equivalency based on days permitted under paragraph (e)(1)(i) of this section. During a computation period an employee spends 2 weeks on vacation with pay. In the ordinary course of the employee’s regular work schedule, the employee would be engaged in the performance of duties for 10 days during the 2-week vacation period. Under § 2530.200b–2, the employee would be credited with at least one hour of service for each of the 10 days during the 2-week vacation for which the employee would ordinarily be engaged in the performance of duties. Under this paragraph the employee is credited with 100 hours of service for the 2-week vacation (10 days multiplied by 10 hours of service per day). If, however, the employee, although paid for a 2-week vacation, spends only one week on vacation, under § 2530.200b–2(b)(3) the employee is not required to be credited with more than 50 hours of service (5 days multiplied by 10 hours per day).

(6) For purposes of this paragraph, in the case of periods of time used as a basis for determining service to be credited to an employee which extend into two computation periods, the plan may credit all hours of service (or other units of service) credited for such a period to the first computation period or the second computation period, or may allocate such hours of service (or other units of service) between the two computation periods on a pro rata basis. Crediting of service under this paragraph must be done consistently with respect to all employees within the same job classifications, reasonably defined.

(7) A plan may combine an equivalency based on working time permitted under paragraph (d) of this section (i.e., hours worked or regular time hours) with an equivalency based on periods of employment permitted under this paragraph if the following conditions are met:

(i) The plan credits an employee with the number of hours worked or regular time hours, as the case may be, equal to the number of hours of service which would be credited to the employee under paragraphs (e)(1) and (2) of this section, for each period of employment for which the employee would be credited with one hour worked or one regular time hour; and

(ii) The plan treats hours worked and regular time hours in the manner prescribed under paragraphs (d)(1) and (2) of this section.

(8) Example. The following example illustrates the application of paragraph (e)(7) of this section. A plan uses the equivalency based on weeks of employment permitted under paragraph (e)(1)(ii) of this section in conjunction with the equivalency based on hours worked permitted under paragraph (d)(1) of this section, as provided in paragraph (e)(7) of this section. During a vesting computation period an employee is paid for the performance of duties for at least 1 hour in each of the first 20 weeks of the computation period and spends the next 2 weeks on a paid vacation. The employee therefore is credited with 900 hours worked for the vesting computation period (20 weeks multiplied by 45 hours per week), receiving no credit for the two weeks of paid vacation. The employee is credited with a year of service for the vesting computation period because he has been credited with more than 870 hours for the computation period.

(f) Equivalencies based on earnings. (1) In the case of an employee whose compensation is determined on the basis of an hourly rate, a plan may determine the number of hours to be credited to the employee in a computation period on the basis of earnings, if:

(i) The employee is credited with the number of hours equal to the total of the employee’s earnings from time to time during the computation period divided by the employee’s hourly rate as
in effect at such times during the computation period, or equal to the employee’s total earnings for the performance of duties during the computation period divided by the employee’s lowest hourly rate of compensation during the computation period, or by the lowest hourly rate of compensation payable to an employee in the same, or a similar job classification, reasonably defined; and

(ii) 870 hours credited under paragraph (f)(1)(i) of this section are treated as equivalent to 1,000 hours of service, and 435 hours credited under paragraph (f)(1)(i) of this section are treated as equivalent to 500 hours of service.

For purposes of this paragraph (f)(1), a plan may divide earnings at premium rates for overtime by the employee’s hourly rate for overtime, rather than the regular time hourly rate.

(2) In the case of an employee whose compensation is determined on a basis other than an hourly rate, a plan may determine the number of hours to be credited to the employee in a computation period on the basis of earnings if:

(i) The employee is credited with the number of hours equal to the employee’s total earnings for the performance of duties during the computation period divided by the employee’s lowest hourly rate of compensation during the computation period, determined under paragraph (f)(3) of this section; and

(ii) 750 hours credited under paragraph (f)(2)(i) of this section are treated as equivalent to 1,000 hours of service, and 375 hours credited under paragraph (f)(2)(i) of this section are treated as equivalent to 500 hours of service.

(3) For purposes of paragraph (f)(2) of this section, an employee’s hourly rate of compensation shall be determined as follows:

(i) In the case of an employee whose compensation is determined on the basis of a fixed rate for a specified period of time other than an hourly rate, a plan may determine the number of hours to be credited to the employee for that vesting computation period by dividing the employee’s total earnings during the computation period by the employee’s lowest hourly rate of compensation in the job classification or by the minimum wage as established from time to time under section 6(a)(1) of the Fair Labor Standards Act of 1938, as amended.

(ii) An hourly employee’s total earnings for the performance of duties during a vesting computation period amount to $4,350. During that calendar year, the employee’s lowest hourly rate of compensation was $5.00 per hour. The plan may determine the number of hours to be credited to the employee for that vesting computation period by dividing $4,350 by $5.00 per hour. The employee is credited with 870 hours for the vesting computation period and is, therefore, credited with a year of service for purposes of vesting.

(iii) During the first 3 months of a vesting computation period an hourly employee is paid at a rate of $3.00 per
hour and earns $675 for the performance of duties; during the next 6 months, the employee is paid at a rate of $3.50 per hour and earns $1,575 for the performance of duties; during the final 3 months the employee is paid at a rate of $3.60 per hour and earns $810 for the performance of duties. The plan may determine the number of hours to be credited to the employee in the computation period under the equivalency set forth in paragraph (f)(1) of this section either (A) by dividing the employee’s earnings for each period during which the employee was paid at a separate rate ($675 divided by $3.00 per hour equals 225 hours; $1,575 divided by $3.50 per hour equals 450 hours; $810 divided by $3.60 per hour equals 225 hours) and adding the hours so obtained (900 hours), or (B) by dividing the employee’s total compensation for the computation period by the employee’s lowest hourly rate during the computation period ($3,020 divided by $3.00 per hour equals 1,0092⁄3 hours). The plan may also divide the employee’s total compensation during the computation period by the lowest hourly rate payable to an employee in the same, or a similar, job classification.

(iv) During a plan’s computation period an hourly employee’s total earnings for the performance of duties consist of $7,500 at a basic rate of $5.00 per hour and $750 at an overtime rate of $7.50 per hour for hours worked in excess of 40 in a week. If the plan uses the equivalency permitted under paragraph (f)(1) of this section, the plan may adjust for the overtime rate in calculating the number of hours to be credited to the employee by adding the employee’s earnings at the basic rate divided by the basic rate and the employee’s earnings at the overtime rate divided by the overtime rate ($7,500 divided by $5.00 per hour, plus $750 divided by $7.50 per hour, or 1,500 hours plus 100 hours), resulting in credit for 1,600 hours for the computation period.

(v) During a plan’s vesting computation period an employee’s lowest weekly rate of compensation is $400 per week. The employee has a regular work schedule of 40 hours per week. The employee’s lowest hourly rate during the vesting computation period is, therefore, $10 per hour ($400 per week divided by 40 hours per week). During the vesting computation period, the employee receives a total of $7,500 for the performance of duties. The plan determines the number of regular time hours to be credited to the employee for the computation period by dividing $7,500 by $10 per hour. The employee is credited with 750 hours for the computation period and is, therefore, credited with a year of service for purposes of vesting.
service upon an employee's return after a one-year break in service:

(i) In the case of a plan which, after the initial eligibility computation period, measures years of service for purposes of eligibility to participate on the basis of eligibility computation periods beginning on anniversaries of an employee's employment commencement date, as permitted under § 2530.202–2(b)(1), the plan shall use the 12-consecutive-month period beginning on an employee's reemployment commencement date (as defined in paragraphs (b)(1)(iii) and (iv) of this section) and, where necessary, subsequent 12-consecutive-month periods beginning on anniversaries of the reemployment of commencement date.

(ii) In the case of a plan which, after the initial eligibility computation period, measures years of service for eligibility to participate on the basis of plan years beginning with the plan year which includes the first anniversary of the initial eligibility computation period, as permitted under § 2530.202–2(b)(2), the plan shall use the 12-consecutive-month period beginning on an employee's reemployment commencement date (as defined in paragraphs (b)(1)(iii) and (iv) of this section and, where necessary, plan years beginning with the plan year which includes the first anniversary of the employee's reemployment commencement date.

(iii) Except as provided in paragraph (b)(1)(iv) of this section, an employee's reemployment commencement date shall be the first day on which the employee is entitled to be credited with an hour of service described in § 2530.200b–2(a)(1) after the first eligibility computation period in which the employee incurs a one-year break in service following an eligibility computation period in which the employee is credited with more than 500 hours of service.

(iv) In the case of an employee who is credited with no hours of service in an eligibility computation period beginning after the employee's reemployment commencement date established under paragraph (b)(1)(iii) of this section, the employee shall be treated as having a new reemployment commencement date as of the first day on which the employee is entitled to be credited with an hour of service described in § 2530.200b–2(a)(1) after such eligibility computation period.

(2) For purposes of section 203(b)(3)(B) of the Act and section 411(a)(6)(B) of the Code (relating to the completion of a year of service for vesting following a one-year break in service), in measuring completion of a year of service upon an employee's return after a one-year break in service, a plan shall use the vesting computation period designated under § 2530.203–2. In the case of a plan which designates a separate vesting computation period for each employee (rather than one vesting computation period for all employees), when an employee who has incurred a one-year break in service later completes an initial hour of service, the plan may change the employee's vesting computation period to a 12-consecutive-month period beginning on the day on which such initial hour of service is completed, provided that the plan follows the rules for changing the vesting computation period for each employee (rather than one vesting computation period for all employees), when an employee who has incurred a one-year break in service later completes an initial hour of service, the plan may change the employee's vesting computation period to a 12-consecutive-month period beginning on the day on which such initial hour of service is completed, provided that the plan follows the rules for changing the vesting computation period set forth in § 2530.203–2(c)(1). Specifically, such a plan must ensure that as a result of the change of the vesting computation period of an employee who has incurred a one-year break in service to the 12-month period beginning on the first day on which the employee later completes an initial hour of service, the employee's vested percentage of the accrued benefit derived from employer contributions will not be less on any date after the change than such non-forfeitable percentage would be in the absence of the change. As under § 2530.203–2(c)(1), the plan will be deemed to satisfy the requirement of that paragraph if, in the case of an employee who has incurred a one-year break in service, the vesting computation period beginning on the day on which the employee completes an hour of service after the one-year break in service begins before the end of the last vesting computation period established before the change of vesting computation periods and, if the employee is credited with 1000 hours of service in both such vesting computation periods, the employee is credited with 2 years of service for purposes of vesting.

(3) For purposes of section 203(b)(3)(B) of the Act and section 411(a)(6)(B) of the act...
the Code (relating to the completion of a year of service for vesting following a one-year break in service), in measuring completion of a year of service upon an employee’s return after a one-year break in service, a plan shall use the vesting computation period designated under §2530.203–2. In the case of a plan which designates a separate vesting computation period for each employee (rather than one vesting computation period for all employees), when an employee who has incurred a one-year break in service later completes an initial hour of service, the plan may change the employee’s vesting computation period to a 12-consecutive-month period beginning on the day on which such initial hour of service is completed, provided that the plan follows the rules for changing the vesting computation period set forth in §2530.203–2(c)(1).

(4) Examples. (i) Employer X maintains a pension plan. The plan uses a calendar year vesting computation period and plan year. As conditions for participation, the plan requires that an employee of X complete one year of service and attain age 25, and, in accordance with §2530.202–2(b)(2), provides that after the initial eligibility computation period, plan years will be used as eligibility computation periods, beginning with the plan year which includes the first anniversary of an employee’s employment commencement date. Thus, under paragraph (a)(3) of this section, the plan must use plan years in measuring one-year breaks in service for eligibility to participate. The plan provides that an employee acquires a nonforfeitable right to 100 percent of the accrued benefit derived from employer contributions upon completion of 10 years of service. Under the plan, for purposes of vesting, years of service completed before an employee attains age 22 are not taken into account. The plan also provides that if an employee has incurred a one-year break in service, in computing the employee’s period of service for eligibility to participate, years of service before such break will not be taken into account until the employee has completed a year of service with X after the employee’s return. The plan further provides that in the case of an employee who has no vested right to an accrued benefit derived from employer contributions, years of service for purposes of eligibility to participate or vesting before a one-year break in service for eligibility or vesting (as the case may be) shall not be required to be taken into account if the number of consecutive one-year breaks in service equals or exceeds the aggregate number of such years of service before such consecutive one-year breaks in service.

(A) Employee A commences employment with X on January 1, 1976 at age 30 and completes a year of service for eligibility to participate and vesting in both the 1976 and 1977 computation periods. A becomes a participant in the plan on January 1, 1977. A terminates employment with X on November 3, 1977, after completing 1,000 hours of service; completes no hours of service from January 1, 1978, incurring a one-year break in service; and is reemployed by X on June 1, 1979. A completes 800 hours of service during the remainder of 1979 and 600 hours of service from January 1, 1980 through May 31, 1980. Under paragraph (b)(1)(iii) of this section, A’s reemployment commencement date is June 1, 1979. By June 1, 1980, A has completed a year of service during the eligibility computation period following his return, and receives credit for his pre-break service to the extent required under section 202 of the Act and section 410 of the Code and the regulations thereunder. The plan is not, however, required to credit A with a year of service for vesting during 1979 because he failed to complete 1,000 hours of service during that vesting computation period. If A completes 400 or more hours of service from June 1, 1980 to December 31, 1980, then A will be credited with one year of service for vesting purposes for the 1980 vesting computation period.

(B) Employee B was born on February 22, 1955 and commenced employment with Employer X on July 1, 1975. B is credited with a year of service for eligibility to participate in the plan for the eligibility computation period beginning on his employment commencement date (July 1, 1975) and a year of service for eligibility and vesting for the 1976 and 1977 plan years. As of the end of the 1977 plan year, B is credited
with 3 years of service for purposes of eligibility to participate, but only one year of service for purposes of vesting. Not having attained age 25, however, B is not admitted to participation in the plan upon completion of his first year of service with X. In the 1978 plan year, B fails to be credited with 500 hours of service, thereby incurring a one-year break in service. As a result of B’s one-year break in service in the 1978 plan year, the year of service for vesting which was earlier credited to B for the 1977 plan year is disregarded because the one-year break in service equals the one year of service credited to B before the one-year break in service. After the end of the 1978 plan year, B does not perform an hour of service with X until February 3, 1979. February 3, 1979, therefore, is B’s reemployment commencement date under paragraph (b)(1)(i) of this section. B fails to be credited with 1,000 hours of service in the first eligibility computation period beginning on February 3, 1979, and also for the vesting computation period beginning January 1, 1979. Because, in accordance with §2530.202–2(b)(2), the plan provides that after the initial eligibility computation period, plan years will be used as eligibility computation periods, under paragraph (b)(1)(ii) of this section the plan must provide that, in measuring completion of a year of service for eligibility to participate after a one-year break in service, plan years beginning with the plan year which includes an employee’s re-employment commencement date will be used. B is credited with 1,000 hours of service for the plan year beginning on January 1, 1980 and is therefore credited with a year of service for the 1980 plan year. Under section 202(b)(3) of the Act and section 410(a)(5)(C) of the Code, as a consequence of B’s completion of a year of service in the 1980 plan year, B’s service before his one-year break in service in the 1978 plan year must be taken into account for eligibility purposes. As conditions of participation, the plan requires that an employee attain age 25 and complete one year of service. Upon his completion of a year of service for the 1980 plan year, B is deemed to have met the plan’s participation requirements as of February 22, 1980, his twenty-fifth birthday, because the year of service completed by B in B’s eligibility computation period beginning on January 1, 1976 is taken into account for eligibility purposes.

(ii) Employer Y maintains a defined benefit pension plan. The plan provides that an employee acquires a nonforfeitable right to 100 percent of the employee’s accrued benefit derived from employer contributions upon completion of 10 years of service. As conditions for participation, the plan requires that an employee of Y complete one year of service and provides that if an employee has incurred a one-year break in service, in computing the employee’s period of service for eligibility to participate, years of service before such break will not be taken into account until the employee has completed a year of service with Y after the employee’s return. In accordance with §2530.202–2(b)(1), the plan provides that after the initial eligibility computation period, eligibility computation periods beginning on anniversaries of an employee’s employment commencement date will be used. Thus, under paragraph (a)(1) of this section, the plan must use computation periods beginning on anniversaries of the employee’s employment commencement date in measuring one-year breaks in service. Employee C’s employment commencement date with Y is February 1, 1975. C is credited with a year of service for eligibility to participate in the plan as of July 1, 1976. C is thereafter credited with a year of service for eligibility to participate in each of the eligibility computation periods beginning on anniversaries of C’s employment commencement date and meets the plan’s eligibility requirements as of February 1, 1976. In accordance with the provisions of the plan, C commences participation in the plan as of July 1, 1976. C is thereafter credited with a year of service for eligibility to participate in each of the eligibility computation periods beginning on anniversaries of C’s employment commencement date (February 1) in 1976, 1977, 1978 and 1979. Thus, as of February 1, 1980, C is credited with 5 years of service for eligibility to participate. In the eligibility computation period beginning on February 1, 1980, C fails to be credited with more than 500 hours of service and therefore incurs a one-year break in service. In the eligibility computation
period beginning on February 1, 1981. C is not credited with an hour of service for the performance of duties until March 1, 1981. Under paragraph (b)(1)(iii) of this section, March 1, 1981 is C’s reemployment commencement date. C terminates employment with Y on May 1, 1981 and fails to be credited with 1000 hours of service in the 12-consecutive-month period beginning on March 1, 1981, or with more than 500 hours of service in the eligibility computation period beginning on February 1, 1981, thereby incurring a second one-year break in service for eligibility to participate. C is credited with no hours of service in the eligibility computation period beginning on February 1, 1982, thereby incurring a third one-year break in service for eligibility to participate, and is likewise credited with no hours of service in the 12-consecutive-month period beginning on March 1, 1982, the anniversary of B’s reemployment commencement date. Under paragraph (b)(1)(iv) of this section, C must therefore be treated as having a new reemployment commencement date as of the first day following the close of the eligibility computation period beginning on February 1, 1982. On January 1, 1984 (before the end of the eligibility computation period beginning February 1, 1983) C is rehired by Y and is credited with an hour of service for the performance of duties. C is therefore treated as having a new reemployment commencement date January 1, 1984. C fails to be credited with more than 500 hours of service in the eligibility computation period beginning on February 1, 1983, thereby incurring a fourth one-year break in service, and fails to be credited with 1000 hours of service in the 12-consecutive-month period beginning on March 1, 1983, the anniversary of C’s original reemployment commencement date. However, in the 12-consecutive-month period beginning on January 1, 1984, C is credited with 1000 hours of service, thus meeting the plan’s requirement that an employee who has incurred a one-year break in service for eligibility to participate must complete a year of service upon the employee’s return in order for years of service before the one-year break in service to be taken into account for purposes of eligibility. Because C’s years of service completed before C’s first one-year break in service must be taken into account under section 202(b) of the Act and section 410(b)(5) of the Code for purposes of eligibility to participate, under §2530.204–2(a)(2) the period beginning on July 1, 1976 (the earliest date on which C was a participant) and extending until January 31, 1980 (the last day before C’s first one-year break in service) must be taken into account for purposes of benefit accrual.

(c) Prior service for eligibility to participate. For rules relating to computing service preceding a break in service for the purpose of eligibility to participate in the plan, see §2530.202–2(c).

(d) Prior service for vesting. For rules relating to computing service preceding a break in service for the purpose of credit toward vesting, see §2530.203–2(d).

§2530.200b–5 Seasonal industries. [Reserved]

§2530.200b–6 Maritime industry.

(a) General. Sections 202(a)(3)(D), 203(b)(2)(D) and 204(b)(3)(E) of the Act and sections 410(a)(3)(D) and 411(a)(5)(D) and (b)(3)(E) of the Code contain special provisions applicable to the maritime industry. In general, those provisions permit statutory standards otherwise expressed in terms of 1,000 hours of service to be applied to employees in the maritime industry as if such standards were expressed in terms of 125 days of service. A plan covering employees in the maritime industry may nevertheless credit service to such employees on the basis of hours of service, as prescribed in §2530.200b–2, including the use of any equivalency permitted under §2530.200b–3, or may credit service to such employees on the basis of elapsed time, as permitted under §2530.200b–9.

(b) Definition. For purposes of sections 202, 203, and 204 of the Act and sections 410 and 411 of the Code, the maritime industry is that industry in which employees perform duties on board commercial, exploratory, service or other vessels moving on the high seas, inland waterways, Great Lakes,
coastal zones, harbors and noncontiguous areas, or on offshore ports, platforms or other similar sites.

(c) Computation periods. For employees in the maritime industry, computation periods shall be established as for employees in any other industry.

(d) Year of service. To the extent that a plan covers employees engaged in the maritime industry, and credits service for such employees on the basis of days of service, such employees who are credited with 125 days of service in the applicable computation period must be credited with a year of service. In the case of a plan covering both employees engaged in the maritime industry and employees not engaged in the maritime industry, service of employees not engaged in the maritime industry shall not be determined on the basis of days of service.

(e) Year of participation for benefit accrual. A plan covering employees engaged in the maritime industry may determine such an employee’s period of service for purposes of benefit accrual on any basis permitted under §§2530.204-2 and 2530.204-3. For purposes of §2530.204-2(c) (relating to partial years of participation), in the case of an employee engaged in the maritime industry who is credited by the plan on the basis of days of service and whose service is not less than 125 days of service during an accrual computation period, the calculation of such employee’s period of service is not taken into account. Thus, the employee must be credited with at least a partial year of participation for that accrual computation period, in accordance with §2530.204-2(c).

(f) Employment commencement date. For purposes of §2530.200b-4 (relating to breaks in service) and §2530.202-2 (relating to eligibility computation periods):

(1) The employment commencement date of an employee engaged in the maritime industry who is credited by the plan on the basis of days of service shall be the first day for which the employee is entitled to be credited with a day of service described in §2530.200b-7(a)(1).

(2)(i) Except as provided in paragraph (f)(2)(ii) of this section, the reemployment commencement date of an employee engaged in the maritime industry shall be the first day for which the employee is entitled to be credited with a day of service described in §2530.200b-7(a)(1) after the first eligibility computation period in which the employee incurs a 1-year break in service following an eligibility computation period in which the employee is credited with more than 62 days of service.

(ii) In the case of an employee engaged in the maritime industry who is credited with no hours of service in an eligibility computation period beginning after the employee’s reemployment commencement date established under paragraph (f)(2)(i) of this section, the employee shall be treated as having a new reemployment commencement date as of the first day for which the employee is entitled to be credited with day of service described in §2530.200b-7(a)(1) after such eligibility computation period.

§2530.200b-7 Day of service for employees in the maritime industry.

(a) General rule. A day of service in the maritime industry which must, as a minimum, be counted for the purposes of determining a year of service, a year of participation for benefit accrual, a break in service and an employment commencement date (or reemployment commencement date) under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code by a plan that credits service by days of service rather than hours of service (as prescribed in §2530.200b-2, or under equivalencies permitted under §2530.200b-3) or elapsed time (as permitted under §2530.200b-9), is a day of service as defined in paragraphs (a)(1), (2) and (3) of this section.

(1) A day of service is each day for which an employee is paid or entitled to payment for the performance of duties for the employer during the applicable computation period.

(2) A day of service is each day for which an employee is paid, or entitled...
§2530.200b–7  29 CFR Ch. XXV (7–1–15 Edition)

To payment, by the employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Notwithstanding the preceding sentence:

(i) No more than 63 days of service are required to be credited under this paragraph (a)(2) to an employee on account of any single continuous period during which the employee performs no duties (whether or not such period occurs in a single computation period);

(ii) A day for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed is not required to be credited to the employee if such payment is made or due under a plan maintained solely for the purpose of complying with applicable workmen’s compensation (including maintenance and care), or unemployment compensation or disability insurance laws; and

(iii) Days of service are not required to be credited for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

For purposes of this paragraph (a)(2), a payment shall be deemed to be made by or due from an employer regardless of whether such payment is made by or due from the employer directly, or indirectly through, among others, a trust, fund, or insurer, to which the employer contributes or pays premiums, and regardless of whether contributions made or due to the trust, fund, insurer or other entity are for the benefit of particular employees or are made on behalf of a group of employees in the aggregate.

(3) A day of service is each day for which back pay, irrespective of mitigation of damages, has been either awarded or agreed to by the employer. Days of service shall not be credited both under paragraph (a)(1) or paragraph (a)(2), as the case may be, and under this subparagraph. Thus, for example, an employee who receives a back pay award following a determination that he or she was paid at an unlawful rate for days of service previously credited will not be entitled to additional credit for the same days of service. Crediting of days of service for back pay awarded or agreed to with respect to periods described in paragraph (a)(2) shall be subject to the limitations set forth in that paragraph. For example, no more than 63 days of service are required to be credited for payments of back pay, to the extent that such back pay is agreed to or awarded for a period of time during which an employee did not or would not have performed duties.

(b) Special rule for determining days of service for reasons other than the performance of duties. In the case of a payment which is made or due on account of a period during which an employee performs no duties, and which results in the crediting of days of service under paragraph (a)(3) of this section, or, in the case of an award or agreement for back pay, to the extent that such award or agreement is made with respect to a period described in paragraph (a)(2) of this section, the number of days of service to be credited shall be determined as follows:

(1) Payments calculated on the basis of units of time. In the case of a payment made or due which is calculated on the basis of units of time, such as days, weeks or months, the number of days of service to be credited shall be the number of regularly scheduled working days included in the units of time on the basis of which the payment is calculated. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of days of service to be credited on the basis of a 5-day workweek, or may provide for such calculation on any reasonable basis which reflects the average days worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(2) Payments not calculated on the basis of units of time. Except as provided in paragraph (b)(3) of this section, in the case of a payment made or due, which is not calculated on the basis of units of time, the number of days of service...
Employee Benefits Security Admin., Labor § 2530.200b-7

to be credited shall be equal to the amount of the payment divided by the employee’s most recent daily rate of compensation before the period during which no duties are performed.

(3) Rule against double credit. Notwithstanding paragraphs (b)(1) and (2) of this section, an employee is not required to be credited on account of a period during which no duties are performed with a number of days of service which is greater than the number of days regularly scheduled for the performance of duties during such period. For purposes of the preceding sentence, in the case of an employee without a regular work schedule, a plan may provide for the calculation of the number of days of service to be credited to the employee for a period during which no duties are performed on the basis of a 5-day workweek, or may provide for such calculation on any reasonable basis which reflects the average hours worked by the employee, or by other employees in the same job classification, over a representative period of time, provided that the basis so used is consistently applied with respect to all employees in the same job classifications, reasonably defined.

(c) Crediting of days of service to computation periods. (1) Except as provided in paragraph (c)(4) of this section, days of service described in paragraph (a)(1) of this section shall be credited to the computation period in which the duties are performed.

(2) Except as provided in paragraph (c)(4) of this section, days of service described in paragraph (a)(2) of this section shall be credited as follows:

(i) Days of service credited to an employee on account of a payment which is calculated on the basis of units of time, such as days, weeks or months, shall be credited to the computation period or computation periods in which the period during which no duties are performed occurs, beginning with the first unit of time to which the payment relates.

(ii) Days of service credited to an employee by reason of a payment which is not calculated on the basis of units of time shall be credited to the computation period in which the period during which no duties are performed occurs, or if the period during which no duties are performed extends beyond one computation period, such hours of service shall be allocated between not more than the first two computation periods on any reasonable basis which is consistently applied with respect to all employees within the same job classifications, reasonably defined.

(3) Except as provided in paragraph (c)(4) of this section, days of service described in paragraph (a)(3) of this section shall be credited to the computation period or periods to which the award or agreement for back pay pertains, rather than to the computation period in which the award, agreement or payment is made.

(4) In the case of days of service to be credited to an employee in connection with a period of no more than 31 days which extends beyond one computation period, all such days of service may be credited to the first computation period or the second computation period. Crediting of days of service under this paragraph must be done consistently with respect to all employees with the same job classifications, reasonably defined.

(d) Other federal law. Nothing in this section shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States or any rule or regulation issued under any such law. Thus, for example, nothing in this section shall be construed as denying an employee credit for a day of service if credit is required by separate federal law. Furthermore, the nature and extent of such credit shall be determined under such law.

(e) Nondaily employees. For maritime employees whose compensation is not determined on the basis of certain amounts for each day worked during a given period, service shall be credited on the basis of hours of service as determined in accordance with §2530.200b-2(a) (including use of any equivalency permitted under §2530.200b-3) or on the basis of elapsed time, as permitted under §2530.200b-9.

(f) Plan document. A plan which credits service on the basis of days of service must state in the plan document the definition of days of service set forth in paragraph (a) of this section, but is not required to state the rules
§ 2530.200b–8 Determination of days of service to be credited to maritime employees.

(a) General rule. For the purpose of determining the days of service which must be credited to an employee for a computation period, a plan shall determine days of service from records of days worked and days for which payment is made or due. Any records may be used to determine days of service to be credited to employees under a plan, even though such records are maintained for other purposes, provided that they accurately reflect the actual number of days of service with which an employee is required to be credited under §2530.200b–7(a). Payroll records, for example, may provide sufficiently accurate data to serve as a basis for determining days of service. If, however, existing records do not accurately reflect the actual number of days of service with which an employee is entitled to be credited, a plan must develop and maintain adequate records. A plan may in any case credit days of service under any method which results in the crediting of no less than the actual number of days of service required to be credited under §2530.200b–7(a). Payroll records, for example, may provide sufficiently accurate data to serve as a basis for determining days of service. If, however, existing records do not accurately reflect the actual number of days of service with which an employee is entitled to be credited, a plan must develop and maintain adequate records. A plan may in any case credit days of service under any method which results in the crediting of no less than the actual number of days of service required to be credited under §2530.200b–7(a). Payroll records, for example, may provide sufficiently accurate data to serve as a basis for determining days of service. If, however, existing records do not accurately reflect the actual number of days of service with which an employee is entitled to be credited, a plan must develop and maintain adequate records. A plan may in any case credit days of service under any method which results in the crediting of no less than the actual number of days of service required to be credited under §2530.200b–7(a).

(b) Determination of pre-effective date days of service. To the extent that a plan is required to determine days of service completed before the effective date of part 2 of title I of the Act (see section 211 of the Act), the plan may use whatever records may be reasonably accessible to it and may make whatever calculations are necessary to determine the approximate number of hours of service completed before such effective date. For example, if a plan or an employer maintaining the plan has, or has access to, only the records of compensation of employees for the period before the effective date, it may derive the pre-effective date days of service by using the daily rate for the period or the days customarily worked. If accessible records are insufficient to make an approximation of the number of pre-effective date days of service for a particular employee or group of employees, the plan may make a reasonable estimate of the days of service completed by such employee or employees during the particular period. For example, if records are available with respect to some employees, the plan may estimate the days of service of other employees in the same job classification based on these records. A plan may use the elapsed time method prescribed under §2530.200b–9 to determine days of service completed before the effective date of part 2 of title I of the Act.

§ 2530.201–1 Coverage; general.

Coverage of the provisions of part 2 of title I of the Act is determined under a multiple step process. First, the plan must be an employee benefit plan as defined under section 3(3) of the Act and §2510.3–3. (See also the definitions of employee welfare benefit plan, section 3(1) of the Act and §2510.3–1 and employee pension benefit plan, section 3(2) of the Act and §2510.3–2). Second, the employee benefit plan must be subject to title I of the Act. Coverage for title I is specified in section 4 of the Act. Third, section 201 of the Act specifies the employee benefit plans subject to title I which are not subject to the minimum standards of part 2 of title I of the Act. Section 2530.201–2 specifies the employee benefit plans subject to title I of the Act which are exempted from coverage under part 2 of title I of the Act and this part (2530).

§ 2530.201–2 Plans covered by part 2530.

This part (2530) shall apply to any employee benefit plan described in section 4(a) of the Act (and not exempted under section 4(b)) other than—

(a) An employee welfare benefit plan as defined in section 3(1) of the Act and §2510.3–1;

(b) A plan which is unfunded and is maintained by an employer primarily for the purpose of providing deferred compensation for a select group of
management or highly compensated employees;

(c) A plan established and maintained by a society, order, or association described in section 501(c)(8) or (9) of the Code, if no part of the contributions to or under such plan are made by employers of participants in such plan;

(d) A trust described in section 501(c)(18) of the Code;

(e) A plan which is established and maintained by a labor organization described in section 501(c)(5) of the Code and which does not at any time after the date of enactment of the Act provide for employer contributions;

(f) Any agreement providing payments to a retired partner or a deceased partner’s successor in interest, as described in section 736 of the Code;

(g) An individual retirement account or annuity described in section 408 of the Code, or a retirement bond described in section 409 of the Code;

(h) An excess benefit plan as described in section 3(36) of the Act.

Subpart B—Participation, Vesting and Benefit Accrual

§ 2530.202–1 Eligibility to participate; general.

(a) Section 202 of the Act and section 410 of the Code contain minimum participation standards relating to certain employee pension benefit plans. In general, an employee pension benefit plan may not require, as a condition of participation in the plan, that an employee complete a period of service with the employer or employers maintaining the plan in excess of limits established by section 202 of the Act and section 410 of the Code and the regulations issued thereunder. Service for this purpose is measured in units of years of service. Section 2530.202–2 sets forth rules relating to the computation periods which a plan must use to determine whether an employee has completed a year of service for purposes of eligibility to participate (‘‘eligibility computation periods’’).

(b) For rules relating to ‘‘service with the employer or employers maintaining the plan’’, see § 2530.210.

§ 2530.202–2 Eligibility computation period.

(a) Initial eligibility computation period. For purposes of section 202(a)(1)(A)(ii) of the Act and section 410(a)(1)(A)(ii) of the Code, the initial eligibility computation period the plan must use is the 12-consecutive-month period beginning on the employment commencement date. An employee’s employment commencement date is the first day for which the employee is entitled to be credited with an hour of service described in § 2530.200b–2(a)(1) for an employer maintaining the plan. (For establishment of a reemployment commencement date following a break in service, see § 2530.200b–4(b)(1)(iii) and (iv).)

(b) Eligibility computation periods after the initial eligibility computation period. In measuring years of service for purposes of eligibility to participate after the initial eligibility computation period, a plan may adopt either of the following alternatives:

(1) A plan may designate 12-consecutive-month periods beginning on the first anniversary of an employee’s employment commencement date and succeeding anniversaries thereof as the eligibility computation period after the initial eligibility computation period; or

(2) A plan may designate plan years beginning with the plan year which includes the first anniversary of an employee’s employment commencement date as the eligibility computation period after the initial eligibility computation period (without regard to whether the employee is entitled to be credited with 1,000 hours of service during such period), provided that an employee who is credited with 1,000 hours of service in both the initial eligibility computation period and the plan year which includes the first anniversary of the employee’s employment commencement date is credited with two years of service for purposes of eligibility to participate.

(c) Service prior to a break in service.

For purposes of applying section 202(b)(4) of the Act and section 410(a)(5)(D) of the Code (relating to years of service completed prior to a break in service for purposes of eligibility to participate), the computation
§ 2530.202–2

29 CFR Ch. XXV (7–1–15 Edition)

periods used by a plan in determining years of service before such break shall be the eligibility computation periods established in accordance with paragraphs (a) and (b) of this section.

(d) Plans with 3-year 100 percent vesting. A plan which, under 202(a)(1)(B)(i) of the Act and section 410(a)(1)(B)(i) of the Code, requires more than one year of service for eligibility to participate in the plan shall use an initial eligibility computation period established under paragraph (a) of this section and eligibility computation periods designated in accordance with paragraph (b) of this section. Thus, for the eligibility computation period after the initial eligibility computation period, such a plan may designate either eligibility computation periods beginning on anniversaries of an employee’s employment commencement date or plan years beginning with the plan year which includes the anniversary of the first day of the initial eligibility computation period.

(e) Alternative eligibility computation period. The following rule is designed primarily for a plan using a recordkeeping system which does not permit the plan to identify an employee’s employment commencement date (or, in the case of an employee who has incurred a one-year break in service, the employee’s reemployment commencement date), but which does permit the plan to identify a period of no more than 31 days during which the employee’s employment commencement date (or reemployment commencement date) occurred.

(1) A plan may use an initial eligibility computation period (or initial computation period for measuring completion of a year of service upon an employee’s return after a one-year break in service) beginning on the first day of a period of no more than 31 days during which the employee’s employment commencement date (or reemployment commencement date) occurred.

(2) If a plan uses an initial eligibility computation period (or initial computation period for measuring completion of a year of service upon an employee’s return after a one-year break in service) permitted under paragraph (e)(1) of this section, the plan shall use the following computation periods after the initial computation period:

(i) If the plan does not use plan years for computation periods after the initial computation period, the plan shall use computation periods beginning on anniversaries of the first day of the initial computation period and ending on anniversaries of the last day of the initial computation period, and including a period of at least 12 consecutive months.

(ii) If the plan uses plan years for computation periods after the initial computation period, the plan shall use plan years beginning with the plan year which includes the anniversary of the first day of the initial computation period.

(3) For purposes of determining an employee’s commencement of participation under section 202(a)(4) of the Act and section 410(a)(4) of the Code, regardless of whether an eligibility computation period permitted under this paragraph includes a period longer than 12 consecutive months, an employee who completes 1,000 hours of service in such eligibility computation period shall be treated as having satisfied the plan’s service requirement for eligibility to participate as of the last day of the 12-consecutive-month period beginning on the first day of such eligibility computation period. In the case of a plan described in section 202(a)(1)(B)(i) of the Act and section 410(a)(1)(B)(i) of the Code, the requirement of the preceding sentence shall apply only with respect to the last year of service required under the plan for eligibility to participate.

(4) Example. A plan maintained by Employer X obtains records from X which indicate the number of hours worked by an employee during a monthly payroll period. The records do not, however, break down the number of hours worked by an employee by days. Thus, after a new employee has begun employment with X it is impossible for the plan to determine the month during which an
The plan provides for semi-annual entry dates of January 1 and July 1, and the employee has met any eligibility requirements of the plan other than the minimum service requirement as of December 31, 1977, the plan must provide that the employee commences participation as of January 1, 1978.

§ 2530.203–1 Vesting; general.

(a) Section 203 of the Act and section 411(a) of the Code contain minimum vesting standards relating to certain employee pension benefit plans. In general, a pension plan subject to section 203 of the Act of section 411(a) of the Code must meet certain requirements relating to an employee’s nonforfeitable (“vested”) right to his or her normal retirement benefit. One of these requirements specifies that an employee’s accrued benefit derived from employer contributions must be vested in accordance with certain schedules. The schedules (or alternative minimum vesting standards) are generally based on the employee’s number of years of service with the employer or employers maintaining the plan. Section 2530.203–2 sets forth rules relating to the computation periods used to determine whether an employee has completed a year of service for vesting purposes (“vesting computation periods”).

(b) For rules relating to service with the employer or employers maintaining the plan, see §2530.210.

§ 2530.203–2 Vesting computation period.

(a) Designation of vesting computation periods. Except as provided in paragraph (b) of this section, a plan may designate any 12-consecutive-month period as the vesting computation period. The period so designated must apply equally to all participants. This requirement may be satisfied even though the actual 12-consecutive-month periods are not the same for all employees (e.g., if the designated vesting computation period is the 12-consecutive-month period beginning on an employee’s employment commencement date and anniversaries of that date). The plan is prohibited, however, from using any period that would result in artificial postponement of vesting credit, such as a period measured...
by anniversaries of the date four months following the employment commencement date.

(b) Plans with 3-year 100 percent vesting. For rules regarding when a participant has a nonforfeitable right to his accrued benefit, see section 202(a)(1)(B)(i) of the Act and section 410(a)(1)(B)(i) of the Code and regulations issued thereunder.

(c) Amendments to change the vesting computation period. (1) A plan may be amended to change the vesting computation period to a different 12-consecutive-month period provided that as a result of such change no employee’s vested percentage of the accrued benefit derived from employer contributions is less on any date after such change than such vested percentage would be in the absence of such change. A plan amendment changing the vesting computation period shall be deemed to comply with the requirements of this subparagraph if the first vesting computation period established under such amendment begins before the last day of the preceding vesting computation period and an employee who is credited with 1,000 hours of service in both the vesting computation period under the plan before the amendment and the first vesting computation period under the plan as amended is credited with 2 years of service for those vesting computation periods. For example, a plan which has been using a calendar year vesting computation period is amended to provide for a July 1–June 30 vesting computation period starting in 1977. Employees who complete more than 1,000 hours of service in both the vesting computation period under the plan before the amendment and the first vesting computation period under the plan as amended are credited with 2 years of service for those vesting computation periods. For example, a plan which has been using a calendar year vesting computation period is amended to provide for a July 1–June 30 vesting computation period starting in 1977. Employees who complete more than 1,000 hours of service in both of the 12-month periods extending from January 1, 1977 to December 31, 1977 and from July 1, 1977 to June 30, 1978 are advanced two years on the plan’s vesting schedule. The plan is deemed to meet the requirements of this subparagraph.

(2) For additional requirements pertaining to changes in the vesting schedule, see section 203(c)(1) of the Act and section 411(a)(10) of the Code and the regulations issued thereunder.

(d) Service preceding a break in service. For purposes of applying section 203(b)(3)(D) of the Act and section 411(a)(6)(D) of the Code (relating to counting years of service before a break in service for vesting purposes), the computation periods used by the plan in computing years of service before such break must be the vesting computation periods. (For application of the break in service rules, see section 203(b)(3)(D) and section 411(a)(6)(D) of the Code and regulations issued thereunder.)

§ 2530.203–3 Suspension of pension benefits upon employment.

(a) General. Section 203(a)(3)(B) of the Act provides that the right to the employer-derived portion of an accrued pension benefit shall not be treated as forfeitable solely because an employee pension benefit plan provides that the payment of benefits is suspended during certain periods of reemployment which occur subsequent to the commencement of payment of such benefits. This section sets forth the circumstances and conditions under which such benefit payments may be suspended. A plan may provide for the suspension of pension benefits which commence prior to the attainment of normal retirement age, or for the suspension of that portion of pension benefits which exceed the normal retirement benefit, or both, for any reemployment and without regard to the provisions of section 203(a)(3)(B) and this regulation to the extent (but only to the extent) that suspension of such benefits does not affect a retiree’s entitlement to normal retirement benefits payable after attainment of normal retirement age, or the actuarial equivalent thereof.

(b) Suspension rules—(1) General rule. A plan may provide for the permanent withholding of an amount which does not exceed the suspendible amount of an employee’s accrued benefit for each calendar month, or for each four or five week payroll period ending in a calendar month, during which an employee is employed in “section 203(a)(3)(B) service” as described in § 2530.203–3(c).

(2) Resumption of payments. If benefit payments have been suspended pursuant to paragraph (b)(1) of this section, payments shall resume no later than the first day of the third calendar month after the calendar month in
which the employee ceases to be employed in section 203(a)(3)(B) service:

Provided, That the employee has complied with any reasonable procedure adopted by the plan for notifying the plan that he has ceased such employment. The initial payment upon resumption shall include the payment scheduled to occur in the calendar month when payments resume and any amounts withheld during the period between the cessation of employment and the resumption of payments, less any amounts which are subject to offset.

(3) Offset rules. A plan which provides for the permanent withholding of benefits may deduct from benefit payments to be made by the plan payments previously made by the plan during those calendar months or pay periods in which the employee was employed in section 203(a)(3)(B) service. Provided, That such deduction or offset does not exceed in any one month 25 percent of that month’s total benefit payment which would have been due but for the offset (excluding the initial payment described in paragraph (b)(2) of this section, which may be subject to offset without limitation).

(4) Notification. No payment shall be withheld by a plan pursuant to this section unless the plan notifies the employee by personal delivery or first class mail during the first calendar month or payroll period in which the plan withholds payments that his benefits are suspended. Such notification shall contain a description of the specific reasons why benefit payments are being suspended, a general description of the plan provisions relating to the suspension of payments, a copy of such provisions, and a statement to the effect that applicable Department of Labor regulations may be found in §2530.203–3 of the Code of Federal Regulations. In addition, the suspension notification shall also describe the procedure for filing such notice and include the forms (if any) which must be filed. Furthermore, if a plan intends to offset any suspendible amounts actually paid during the periods of employment in section 203(a)(3)(B) service, the notification shall identify specifically the periods of employment, the suspendible amounts which are subject to offset, and the manner in which the plan intends to offset such suspendible amounts. Where the plan’s summary plan description (SPD) contains information which is substantially the same as information required by this paragraph (b)(4), the suspension notification may refer the employee to relevant pages of the SPD for information as to a particular item, provided the employee is informed how to obtain a copy of the SPD, or relevant pages thereof, and provided requests for referenced information are honored within a reasonable period of time, not to exceed 30 days.

(5) Verification. A plan may provide that an employee must notify the plan of any employment. A plan may request from an employee access to reasonable information for the purpose of verifying such employment. Furthermore, a plan may provide that an employee must, at such time and with such frequency as may be reasonable, as a condition to receiving future benefit payments, either certify that he is unemployed or provide factual information sufficient to establish that any employment does not constitute section 203(a)(3)(B) service if specifically requested by the plan administrator. Once an employee has furnished the required certification or information, the plan must forward, at the next regularly scheduled time for payment of benefits, all payments which had been withheld pursuant to this paragraph (b)(5) except to the extent that payments may be withheld and offset pursuant to other provisions of this regulation.

(6) Status determination. If a plan provides for benefits suspension, the plan shall adopt a procedure, and so inform employees, whereunder an employee may request, and the plan administrator in a reasonable amount of time will render, a determination of whether
specific contemplated employment will be section 203(a)(3)(B) service for purposes of plan provisions concerning suspension of benefits. Requests for status determinations may be considered in accordance with the claims procedure adopted by the plan pursuant to section 503 of the Act and applicable regulations.

(7) Presumptions. (i) A plan which has adopted verification requirements described in paragraph (b)(5) of this section, and which complies with the notice requirements set forth in paragraph (b)(7)(ii) of this section may provide that whenever the plan fiduciaries become aware that a retiree is employed in section 203(a)(3)(B) service and the retiree has not complied with the plan’s reporting requirements with regard to that employment, the plan fiduciaries may, unless it is unreasonable under the circumstances to do so, act on the basis of a rebuttable presumption that the retiree had worked a period exceeding the plan’s minimum number of hours for that month. In addition, a plan covering persons employed in the building trades which has adopted verification requirements described in paragraph (b)(5) of this section and which complies with the notice requirements set forth in paragraph (b)(7)(ii) of this section may provide that whenever the plan fiduciaries become aware that a retiree is employed in section 203(a)(3)(B) service and the retiree has not complied with the plan’s reporting requirements with regard to that employment, the plan fiduciaries may, unless it is unreasonable under the circumstances to do so, act on the basis of a rebuttable presumption that the retiree engaged in such employment for the same employer in work at that site for so long before the work in question as that same employer performed that work at that construction site.

(ii) A plan which provides for a presumption described in paragraph (b)(7)(i) of this section may employ such presumption only if the following requirements are met. The plan must describe its employment verification requirements and the nature and effect of such presumption in the plan’s summary plan description and in any communication to plan participants which relates to such verification requirements (for example, employment reporting reminders or forms), and retirees must be furnished such disclosure, whether through receipt of the above communications or by special distribution, at least once every 12 months.

(c) Section 202(a)(3)(B) service—(1) Plans other than multiemployer plans. In the case of a plan other than a multiemployer plan, as defined in section 3(37) of the Act, the employment of an employee, subsequent to the time the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment, results in section 203(a)(3)(B) service during a calendar month, or during a four or five week payroll period ending in a calendar month, if the employee, in such month or payroll period,

(i) Completes 40 or more hours of service (as defined in 29 CFR 2530.200b–2(a)(1) and (2)) for an employer which maintains the plan, including employers described in §2530.210(d) and (e), as of the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment; or

(ii) Receives from such employer payment for any such hours of service performed on each of 8 or more days (or separate work shifts) in such month or payroll period. Provided, That the plan has not for any purpose determined or used the actual number of hours of service which would be required to be credited to the employee under §2530.200b–2(a)(2). (2) Multiemployer plans. In the case of a multiemployer plan, as defined in section 3(37) of the Act, the employment of an employee subsequent to the time the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment results in section 203(a)(3)(B) service during a calendar month, or during a four or five week payroll period ending in a calendar month, if the employee, in such month or payroll period:

—Completes 40 or more hours of service (as defined in §2530.200b–2(a)(1) and (2)) or
Employee Benefits Security Admin., Labor

§ 2530.203-3

—Receives payment for any such hours of service performed on each of 8 or more days (or separate work shifts) in such month or payroll period. Provided, That the plan has not for any purpose determined or used the actual number of hours of service which would be required to be credited to the employee under §2530.200(b)(1)(ii)(a); in

—An industry in which employees covered by the plan were employed and accrued benefits under the plan as a result of such employment at the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment, and

—A trade or craft in which the employee was employed at any time under the plan, and

—The geographic area covered by the plan at the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment.

(i) Industry. The term “industry” means the business activities of the types engaged in by any employers maintaining the plan.

Example. One of the employers contributing to a multiemployer plan engages in heavy construction, another in textile manufacturing, and another in communications. Employee E began his career as an employee of an employer engaged in heavy construction. Later E was employed by an employer in communications. With both employers, E accrued benefits under the plan. If E retires and then becomes reemployed in the same trade or craft and in the same geographic area, employment by E in either heavy construction, communications or textile manufacturing, whether or not with an employer who contributes to the plan or in a self-employed capacity, may be considered by the plan to be employment in the same industry, assuming that employees covered by the plan were accruing benefits as a result of employment in these industries at the time E commenced receiving benefits. This is true even though E did not previously accrue benefits as a result of employment with an employer engaged in textile manufacturing because other employees covered by the plan were employed in that industry and were accruing benefits under the plan as a result of such employment at the time when benefit payments to E commenced or would have commenced if E had not returned to employment.

(ii) Trade or craft. A trade or craft is

(A) a skill or skills, learned during a significant period of training or practice, which is applicable in occupations in some industry,

(B) a skill or skills relating to selling, retailing, managerial, clerical or professional occupations, or

(C) supervisory activities relating to a skill or skills described in (A) or (B) of this paragraph (c)(2)(ii).

For purposes of this paragraph (c)(2)(ii), the determination whether a particular job classification, job description or industrial occupation constitutes or is included in a trade or craft shall be based upon the facts and circumstances of each case. Factors which may be examined include whether there is a customary and substantial period of practical, on-the-job training or a period of related supplementary instruction. Notwithstanding any other factor, the registration of an apprenticeship program with the Bureau of Apprenticeship and Training of the Employment Training Administration of the U.S. Department of Labor is sufficient for the conclusion that a skill or skills which is the subject of the apprenticeship program constitutes a trade or craft.

Example. Participation in a multiemployer plan is limited solely to electricians. Electrician E retired and then became reemployed as a foreman of electricians. Because a “trade or craft” includes related supervisory activities, E remains within his trade or craft for purposes of this section.

(iii) Geographic area covered by the plan. (A) With the exception of a plan covering employees in a maritime industry, the “geographic area covered by the plan” consists of any state or any province of Canada in which contributions were made or were required to be made by or on behalf of an employer and the remainder of any Standard Metropolitan Statistical Area (SMSA) which falls in part within such state, determined as of the time that the payment of benefits commenced or would have commenced if the employee had not returned to employment.

Example. A multiemployer plan covers plumbers in Pennsylvania. All contributing employers have always been located within Pennsylvania. Accordingly, the “geographic area covered by the plan” consists of Pennsylvania and any SMSAs which fall in part within Pennsylvania. Thus, for example, in the case of the Philadelphia SMSA, Burlington, Camden and Gloucester Counties in New Jersey are within the “geographic area covered by the plan”.

(B) [Reserved—for definition of the geographic area covered by a plan that
§2530.204–1

29 CFR Ch. XXV (7–1–15 Edition)

covers employees in a maritime industry.

For purposes of this paragraph (c)(2)(iii), contributions shall not include amounts contributed: After December 31, 1978 by or on behalf of an employer where no contributions were made by or on behalf of that employer before that date, if the primary purpose of such contribution is to allow for the suspension of plan benefits in a geographic area not otherwise covered by the plan; or with respect to isolated projects performed in states where plan participants were not otherwise employed.

(3) Employment in a maritime industry.

For plans covering employees employed in a maritime industry, as defined in §2530.200b–6, the standard of "five or more days of service, as defined in §2530.200b–7(a)(1)" shall be used in lieu of the standard "40 or more hours of service", for purposes of determining whether an employee is employed in section 203(a)(3)(B) service.

(d) Suspendable amount—(1) Life annuity.

In the case of benefits payable periodically on a monthly basis for as long as a life (or lives) continues, such as a straight life annuity or a qualified joint and survivor annuity, a plan may provide that an amount not greater than the portion of a monthly benefit payment derived from employer contributions may be withheld permanently for a calendar month, or for a four or five week payroll period ending in a calendar month, in which the employee is employed in section 203(a)(3)(B) service.

(2) Other benefit forms.

In the case of benefits payable in a form other than the form described in paragraph (d)(1) of this section, a plan may provide for the permanent withholding of an amount of the employer-derived portion of benefit payments for a calendar month, or for a four or five week payroll period ending in a calendar month, in which the employee is employed in section 203(a)(3)(B) service, not exceeding the lesser of—

(i) The amount of benefits which would have been payable to the employee if he had been receiving monthly benefits under the plan since actual retirement age commencing at actual retirement age; or

(ii) The actual amount paid or scheduled to be paid to the employee for such month. Payments which are scheduled to be paid less frequently than monthly may be converted to monthly payments for purposes of this paragraph (d)(2)(ii).

(Approved by the Office of Management and Budget under control number 1210–0048)


§2530.204–1 Year of participation for benefit accrual.

(a) General. Section 204(b)(1) of the Act and section 411(b)(1) of the Code contain certain requirements relating to benefit accrual under a defined benefit pension plan. Some of these requirements are based on the number of years of participation included in an employee's period of service. Paragraph (b) of this section relates to service which must be taken into account in determining an employee's period of service for purposes of benefit accrual. Section 2530.204–2 sets forth rules relating to the computation periods to be used in measuring years of participation for benefit accrual ("accrual computation periods").

(b) Service which may be disregarded for purposes of benefit accrual. 1) In calculating an employee's period of service for purposes of benefit accrual under a defined benefit pension plan, section 204(b)(3) of the Act and section 411(b)(3) of the Code permit the following service to be disregarded: service before an employee first becomes a participant in the plan; service which is not required to be taken into account under section 202(b) of the Act and section 410(b)(5) of the Code (relating to one-year breaks in service for purposes of eligibility to participate); and service which is not required to be taken into account under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code (relating to 12-consecutive-month periods during which an employee's service is less than 1,000 hours). In addition, in calculating an employee's period of service for purposes of benefit accrual, a defined benefit plan shall not be required
(2) Example. The following example illustrates paragraph (b)(1) of this section. A plan has a calendar year vesting and accrual computation period and, under §2530.202-2 (a) and (b)(1), uses eligibility computation periods beginning on an employee’s employment commencement date and anniversaries thereof. The plan provides that an employee who has at least 10 years of service has a vested right to 100 percent of his accrued benefit derived from employer contributions. The plan provides that an employee who is credited with at least 1,000 hours of service in a calendar year accrual computation period is credited with at least partial year of participation for purposes of benefit accrual. An employee whose birthday is October 16, 1956, begins employment with an employer maintaining the plan on January 1, 1977. Under §2530.202-2(a)(1), January 1, 1977 is the employee’s employment commencement date and the calendar year 1977 is the employee’s initial eligibility computation period. The employee completes at least 1,000 hours of service in each of the calendar years from 1977 through 1981. On January 1, 1982 the employee is admitted to participation in the plan, having met the plan’s age requirement (25 years) and service requirement (one year of service) for eligibility to participate. In 1982, the employee is credited with the number of hours of service required for a full year of participation (i.e., more than 1,000 hours of service). Under §2530.202-2(c), for purposes of applying section 202(b)(4) of the Act and section 410(a)(5)(D) of the Code (relating to years of service completed before a break in service for purposes of eligibility to participate), eligibility computation periods beginning on the employee’s employment commencement date and anniversaries thereof are used under the plan to measure service prior to a break in service (in addition, under §2530.200b-4(a)(2), the same eligibility computation periods are used in measuring one-year breaks in service for purposes of eligibility to participate). Thus, as of January 1, 1983, the employee is credited with six years of service for purposes of eligibility to participate and is credited with one year of participation. In accordance with section 203(b)(1)(A) of the Act and section 411(a)(4)(A) of the Code, the plan provides that years of service completed before age 22 are disregarded for purposes of vesting. As of January 1, 1983, therefore, the employee is credited with four years of service for purposes of vesting. In 1983 the employee terminates employment with the employer, incurring one-year breaks in service in each of the calendar years from 1983 through 1986. As of December 31, 1986, the employee’s consecutive one-year breaks in service equal the employee’s four years of service for vesting before such breaks. Under section 203(b)(3)(D) of the Act and section 410(a)(5)(D) of the Code and the terms of the plan, the four years of service for vesting completed by the employee before his four consecutive one-year breaks in service are not taken into account for purposes of vesting. Under paragraph (b)(1) of this section, therefore, in calculating the employee’s period of service for purposes of benefit accrual, the plan may disregard the year of participation completed by the employee before his four consecutive one-year breaks in service for vesting, because the four consecutive one-year breaks in service equal the four years of service credited to the employee for vesting. The employee is re-employed by the employer on January 1, 1987 completing an hour of service on that date. Under §2530.200b-4(b)(1), therefore, January 1, 1987 is the employee’s reemployment commencement date. In 1987, the employee completes the number of hours of service required for a full year of participation (i.e., more than 1,000 hours of service). For 1987, therefore, the employee is credited with a year of service for purposes of eligibility to participate and vesting, and with a year of participation. As of December 31, 1987, the employee is credited with one year of service for purposes of vesting, since service before the employee’s four consecutive one-year breaks in service—including the year of service completed in 1982—
is not taken into account. Because under paragraph (b)(1) of this section, the year of participation credited to the employee for 1982 is not required to be taken into account for purposes of benefit accrual, the employee is credited with one year of participation as of December 31, 1987.

§ 2530.204–2 Accrual computation period.

(a) Designation of accrual computation periods. A plan may designate any 12-consecutive-month period as the accrual computation period except that the period so designated must apply equally to all participants. This requirement may be satisfied even though the actual time periods are not the same for all participants. For example, the accrual computation period may be designated as the vesting computation period, the plan year, or the 12-consecutive-month period beginning on either of two semi-annual dates designated for entry to participation under a plan.

(b) Participation prior to effective date. For purposes of applying the accrual rules of section 204(b)(1)(D) of the Act and section 411(b)(1)(D) of the Code (relating to accrual requirements for defined benefit plans for periods prior to the effective date of those sections), all service from the date of participation in the plan as determined in accordance with applicable plan provisions, shall be taken into account in determining an employee’s period of service. When the plan documents do not provide a definite means for determining the date of commencement of participation, the date of commencement of employment covered under the plan during the period that the employer maintained the plan shall be presumed to be the date of commencement of participation in the plan. The plan may rebut this presumption by demonstrating from circumstances surrounding the operation of the plan, such as the date of commencement of mandatory employee contributions, that participation actually began on a later date.

(c) Partial year of participation. (1) Under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code, in calculating an employee’s period of service for purposes of benefit accrual, a plan is not required to take into account a 12-consecutive-month period during which the employee’s service is less than 1,000 hours of service. In measuring an employee’s service for purposes of section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code, a plan shall use the accrual computation period designated under paragraph (a) of this section. Under section 204(b)(3)(B) of the Act and section 411(b)(3)(B) of the Code, in the case of an employee whose service is not less than 1,000 hours of service during an accrual computation period, the calculation of such employee’s period of service will not be treated as made on a reasonable and consistent basis unless service during such computation period is taken into account. To the extent that the employee’s service during the accrual computation period is less than the service required under the plan for a full year of participation, the employee must be credited with a partial year of participation equivalent to no less than a ratable portion of a full year of participation.

(2) For purposes of calculating the portion of a full year of participation to be credited to an employee whose service during a computation period is not less than 1,000 hours of service but is less than service required for a full year of participation in the plan, the plan may credit the employee with a greater portion of a full year of participation than a ratable portion, or may credit an employee with a full year of participation even though the employee’s service is less than the service required for a full year of participation, provided that such crediting is reasonable and is consistent for all employees within the same job classifications, reasonably established.

(3) In the case of an employee who commences participation in a plan (or recommences participation in the plan upon the employee’s return after one or more 1-year breaks in service) on a date other than the first day of an applicable accrual computation period, all hours of service required to be credited to the employee during the entire accrual computation period, including
hours of service credited to the employee for the portion of the computation period before the date on which the employee commences (or recommences) participation, shall be taken into account in determining whether the employee has 1,000 or more hours of service for purposes of section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code. If such employee’s service is not less than 1,000 hours in such accrual computation period, the employee must be credited with a partial year of participation which is equivalent to no less than a ratable portion of a full year of participation for service credited to the employee for the portion of the computation period after the date of commencement (or re-commencement) of participation.

(4) Examples. The following are examples of reasonable and consistent methods for crediting partial years of participation:

(i) A plan requires 2,000 hours of service for a full year of participation. An employee who is credited during a computation period with no less than 1,000 hours of service but less than 2,000 hours of service is credited with a partial year of participation equal to a portion of a full year of participation determined by dividing the number of hours of service credited to the employee by 2,000.

(ii) A plan requires 2,000 hours of service for a full year of participation. The plan credits service in an accrual computation period in accordance with the following table:

<table>
<thead>
<tr>
<th>Hours of service credited</th>
<th>Percentage of full year of participation credited</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>50</td>
</tr>
<tr>
<td>1001 to 1200</td>
<td>60</td>
</tr>
<tr>
<td>1201 to 1400</td>
<td>70</td>
</tr>
<tr>
<td>1401 to 1600</td>
<td>80</td>
</tr>
<tr>
<td>1601 to 1800</td>
<td>90</td>
</tr>
<tr>
<td>1801 and above</td>
<td>100</td>
</tr>
</tbody>
</table>

Under this method of crediting partial years of participation, each employee who is credited with not less than 1,000 hours of service is credited with at least a ratable portion of a full year of participation.

(iii) A plan provides that each employee who is credited with at least 1,000 hours of service in an accrual computation period must receive credit for at least a partial year of participation for that computation period. For full accrual, however, the plan requires that an employee must be credited with a specified number of hours worked; employees who meet the 1,000 hours of service requirement but who are not credited with the specified number of hours worked required for a full year of participation are credited with a partial year of participation on a prorata basis. For example, if the plan requires 1,500 hours worked for full accrual, an employee with 1,500 hours worked would be credited with full accrual, but an employee with 1,000 hours worked and 500 other hours of service would be credited with $\frac{3}{4}$ of full accrual. The plan’s method of crediting service for accrual purposes is consistent with the requirements of this paragraph. It should be noted, however, that use of hours worked as a basis for prorating benefit accrual may result in discrimination prohibited under section 401(a)(4) of the Code.

(iv) Example. Employee A is employed on June 1, 1980, in service covered by a plan with a calendar year accrual computation period, and which requires 1,800 hours of service for a full accrual. Employee A completes 500 hours from June 1, 1980, to December 31, 1980, and completes 100 hours per month in each month during 1981. A is admitted to participation on July 1, 1981. A is credited with 1,200 hours of service for the accrual computation period beginning January 1, 1981. Under the rules set forth in paragraph (c)(3) of this section, A is required to be credited with not less than one-third of a full accrual (600 hours divided by 1,800 hours).

(d) Prohibited double proration. (1) In the case of a defined benefit plan that (i) defines benefits on a basis which has the effect of prorating benefits to reflect less than full-time employment or less than maximum compensation (as the case may be), the plan may not further prorate benefit accrual under section 204(b)(3)(B) of the Act and section 411(b)(3)(B) of the Code by crediting less than full years of participation, as would otherwise be permitted under paragraph (c) of this section. These
plans must credit, except when service may be disregarded under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code (relating to less than 1,000 hours of service), less-than-full-time employees with a full year of participation for the purpose of accrual of benefits.

(2) Examples. (i) A plan’s defined benefit formula provides that the annual retirement benefit shall be 2 percent of the average compensation in all years of participation multiplied by the number of years of participation. Employee A is a full-time employee who has completed 2,000 hours during each of 20 accrual computation periods. A’s average hourly rate was $5 an hour. Thus, A’s average compensation for each year during participation in the plan is $10,000 ($5 per hour multiplied by 2,000 hours). If the plan states that a full year of participation is 2,000 hours, then A’s annual retirement benefits, if he retired at that time, would be $4,000 ($10,000 per year of compensation × .02 × 20 years of participation). Employee B, however, is a part-time employee who completes 1,000 hours of service during each of 20 accrual computation periods. Like A, B’s average hourly rate is $5 per hour. Thus, B’s average compensation for his total years of participation is $5,000 ($5 per hour multiplied by 1,000 hours). Thus, B’s annual retirement benefit would be $2,000 ($5,000 average compensation × .02 × 10 years of participation).

(ii) If the plan adjusts the average compensation during plan participation to reflect full compensation, then the plan may prorate years of participation. Thus, the average full annual compensation for B would be $10,000 rather than the $5,000 actually paid. Employee B’s annual retirement benefit would then be $2,000 ($10,000 average full compensation × .02 × 10 years of participation).

(e) Amendments to change accrual computation periods. (1) A plan may be amended to change the accrual computation period to a different 12-consecutive-month period, provided that the period between the end of the last accrual computation period under the plan as in effect before such amendment and the beginning of the first accrual computation period under the plan as amended is treated as a partial accrual computation period in accordance with the rules set forth in paragraph (e)(2) of this section.

(2) In the case of a partial accrual computation period, the following rules shall apply:

(i) A plan having a minimum service requirement expressed in hours of service (or other units of service) for benefit accrual in a full accrual computation period (as permitted under section 204(b)(3)(B) of the Act and section 411(b)(3)(B) of the Code) may apply a minimum service requirement for benefit accrual in a partial accrual computation period which is equal to the plan’s minimum service requirement for benefit accrual in a full accrual computation period, multiplied by the ratio of the length of the partial accrual computation period to a full year.

(ii) In the case of a participant who meets a plan’s minimum service requirement for benefit accrual in a full accrual computation period (as permitted under paragraph (e)(2)(i) of this section), the plan shall credit the participant with at least a partial year of participation for purposes of benefit accrual. Credit for a partial accrual computation period shall be determined in accordance with paragraphs (c) and (d) of this section.
(3) Example. Effective October 1, 1977, a plan is amended to change the accrual computation period from the 12-consecutive-month period beginning on January 1 to the 12-consecutive-month period beginning on October 1. The period from January 1, 1977 to September 30, 1977 must be treated as a partial accrual computation period. The plan has a requirement that a participant must be credited with 1,000 hours of service in an accrual computation period in order to be credited with a year of participation for purposes of benefit accrual. For the partial accrual computation period the plan may require a participant to be credited with 750 hours of service in the partial accrual computation period in order to receive credit for purposes of benefit accrual (1,000 hours of service multiplied by the ratio of 9 months to 12 months). To the extent permitted under paragraph (d) of this section, the plan may prorate accrual credit on whatever basis the plan uses to prorate accrual credit for employees whose service is 1,000 hours of service or more but less than service required for full accrual in a full accrual computation period.

§ 2530.204–3 Alternative computation methods for benefit accrual.

(a) General. Under section 204(b)(3)(A) of the Act and section 411(b)(3)(A) of the Code, a defined benefit pension plan may determine an employee’s service for purposes of benefit accrual on the basis of computation periods, as specified in § 2530.204–2, or on any other basis which is reasonable and consistent and which takes into account all covered service during the employee’s participation in the plan which is included in a period of service required to be taken into account under section 202(b) of the Act and section 410(a)(5) of the Code. If, however, a plan determines an employee’s service for purposes of benefit accrual on a basis other than computation periods, it must be possible to prove that, despite the fact that benefit accrual under the plan is not based on computation periods, the plan’s provisions meet at least one of the three benefit accrual rules of section 204(b)(1) of the Act and section 411(b)(1) of the Code under all circumstances. Further, a plan which does not provide for benefit accrual on the basis of computation periods may not disregard service under section 204(b)(3)(C) of the Act and section 411(b)(3)(C) of the Code.

(b) Examples. The following are examples of methods of determining an employee’s period of service for purposes of benefit accrual under which an employee’s period of service is not determined on the basis of computation periods but which may be used by a plan provided that the requirements of paragraph (a) of this section are met:

(1) Career compensation. A defined benefit formula based on a percentage of compensation earned in a participant’s career or during participation, with no variance depending on hours completed in given periods.

(2) Credited hours. A defined benefit formula pursuant to which an employee is credited with a specified amount of accrual for each hour of service (or hour worked or regular time hour) completed by the employee during his or her career.

(3) Elapsed time. See § 2530.200b–9(e).

§ 2530.204–4 Deferral of benefit accrual.

For purposes of section 204(b)(1)(E) of the Act and section 411(b)(1)(E) of the Code (which permit deferral of benefit accrual until an employee has 2 continuous years of service), an employee shall be credited with a year of service for each computation period in which he or she completes 1,000 hours of service. The computation period shall be the eligibility computation period designated in accordance with § 2530.202–2.

Subpart C—Form and Payment of Benefits

§ 2530.205 [Reserved]

§ 2530.206 Time and order of issuance of domestic relations orders.

(a) Scope. This section implements section 1001 of the Pension Protection Act of 2006 by clarifying certain timing issues with respect to domestic relations orders and qualified domestic relations orders under the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1001 et seq. The examples herein illustrate the
Application of this section in certain circumstances. This section also applies in circumstances not described in the examples.

(b) Subsequent domestic relations orders. (1) Subject to paragraph (d)(1) of this section, a domestic relations order shall not fail to be treated as a qualified domestic relations order solely because the order is issued after, or revokes, another domestic relations order or qualified domestic relations order.

(2) The rule described in paragraph (b)(1) of this section is illustrated by the following examples:

Example (1). Subsequent domestic relations order between the same parties. Participant and Spouse divorce, and the administrator of Participant’s 401(k) plan receives a domestic relations order. The administrator determines that the order is a QDRO. The QDRO allocates a portion of Participant’s benefits to Spouse as the alternate payee. Subsequently, before benefit payments have commenced, Participant and Spouse seek and receive a second domestic relations order. The second order reduces the portion of Participant’s benefits that Spouse was to receive under the QDRO. The second order does not fail to be treated as a QDRO solely because the second order is issued after, and reduces the prior assignment contained in the first order. The result would be the same if the order were instead to increase the prior assignment contained in the first order.

Example (2). Subsequent domestic relations order between different parties. Participant and Spouse 1 divorce and the administrator of Participant’s 401(k) plan receives a domestic relations order. The administrator determines that the order is a QDRO. The QDRO allocates a portion of Participant’s benefits to Spouse 1 as the alternate payee. Participant marries Spouse 2, and then they divorce. Participant’s 401(k) plan administrator subsequently receives a domestic relations order pertaining to Spouse 2. The order assigns to Spouse 2 a portion of Participant’s 401(k) benefits not already allocated to Spouse 1. The second order does not fail to be a QDRO solely because the second order is issued after the plan administrator has determined that an earlier order pertaining to Spouse 1 is a QDRO.

(c) Timing. (1) Subject to paragraph (d)(1) of this section, a domestic relations order shall not fail to be treated as a qualified domestic relations order solely because of the time at which it is issued.

(2) The rule described in paragraph (c)(1) of this section is illustrated by the following examples:

Example (1). Orders issued after death. Participant and Spouse divorce, and the administrator of Participant’s plan receives a domestic relations order, but the administrator finds the order deficient and determines that it is not a QDRO. Shortly thereafter, Participant dies while actively employed. A second domestic relations order correcting the defects in the first order is subsequently submitted to the plan. The second order does not fail to be treated as a QDRO solely because it is issued after the death of the Participant. The result would be the same even if no order had been issued before the Participant’s death, in other words, the order issued after death were the only order.

Example (2). Orders issued after divorce. Participant and Spouse divorce. As a result, Spouse no longer meets the definition of “surviving spouse” under the terms of the plan. Subsequently, the plan administrator receives a domestic relations order requiring that Spouse be treated as the Participant’s surviving spouse for purposes of receiving a death benefit payable under the terms of the plan only to a participant’s surviving spouse. The order does not fail to be treated as a QDRO solely because, at the time it is issued, Spouse no longer meets the definition of a “surviving spouse” under the terms of the plan.

Example (3). Orders issued after annuity starting date. Participant retires and begins receipt of benefits in the form of a straight life annuity, equal to $1,000 per month, and with respect to which Spouse has consented to the waiver of the surviving spousal rights provided under the plan and section 205 of ERISA. Subsequent to the commencement of benefits (in other words, subsequent to the annuity starting date as defined in section 205(h)(2) of ERISA and as further explained in 26 CFR 1.401(a)–20, Q&A–10(b)), Participant and Spouse divorce and present the plan with a domestic relations order requiring 50 percent ($500) of Participant’s future monthly annuity payments under the plan to be paid instead to Spouse, as an alternate payee (so that monthly payments of $500 are to be made to Spouse during Participant’s lifetime). Pursuant to paragraph (c)(1) of this section, the order does not fail to be a QDRO solely because it is issued after the annuity starting date. If the order instead had required payments to Spouse for the lifetime of Spouse, this would constitute a reannuitization with a new annuity starting date, rather than merely allocating to Spouse a part of the determined annuity payments due to Participant, so that the order, while not failing to be a QDRO because of the timing of the order, would fail to meet the requirements of section 206(d)(3)(D)(i) of ERISA (unless the plan otherwise permits such a change after the participant’s annuity starting date). See 29 CFR 2530.206(d)(2), Example (4).
(d) Requirements and protections. (1) Any domestic relations order described in this section shall be a qualified domestic relations order only if the order satisfies the same requirements and protections that apply under section 206(d)(3) of ERISA.

(2) The rule described in paragraph (d)(1) of this section is illustrated by the following examples:

Example (1). Type or form of benefit. Participant and Spouse divorce, and their divorce decree provides that the parties will prepare a domestic relations order assigning 50 percent of Participant’s benefits under a 401(k) plan to Spouse to be paid in monthly installments over a 10-year period. Shortly thereafter, Participant dies while actively employed. A domestic relations order consistent with the divorce decree is subsequently submitted to the 401(k) plan; however, the plan does not provide for 10-year installment payments of the type described in the order. Pursuant to paragraph (c)(1) of this section, the order does not fail to be treated as a QDRO solely because it is issued after the death of Participant, but the order would fail to be a QDRO under section 206(d)(3)(D)(i) and paragraph (d)(1) of this section because the order requires the plan to provide a type or form of benefit, or any option, not otherwise provided under the plan.

Example (2). Segregation of payable benefits. Participant and Spouse divorce, and the administrator of Participant’s plan receives a domestic relations order under which Spouse would begin to receive benefits immediately if the order is determined to be a QDRO. The plan administrator separately accounts for the amounts covered by the domestic relations order as is required under section 206(d)(3)(H)(v) of ERISA. The plan administrator finds the order deficient and determines that it is not a QDRO. Subsequently, after the expiration of the segregation period pertaining to that order, the plan administrator receives a second domestic relations order relating to the same parties under which Spouse would begin to receive benefits immediately if the order is determined to be a QDRO. The second order, however, would fail to be a QDRO under section 206(d)(3)(D)(iii) and paragraph (d)(1) of this section because the second order is issued after the annuity starting date and present the plan with a domestic relations order that eliminates the straight life annuity based on Participant’s life and provides for Spouse, as alternate payee, to receive all future benefits in the form of a straight life annuity based on the life of Spouse. The plan does not allow reannuitization with a new annuity starting date, as defined in section 205(b)(2) of ERISA (and as further explained in 26 CFR 1.401(a)-20, Q&A–15(b)). Pursuant to paragraph (c)(1) of this section, the order does not fail to be a QDRO solely because it is issued after the annuity starting date, but the order would fail to be a QDRO under section 206(d)(3)(D)(i) and paragraph (d)(1) of this section because the order requires the plan to provide a type or form of benefit, or any option, not otherwise provided under the plan. However, the order would not fail to be a QDRO under section 206(d)(3)(D)(i) and paragraph (d)(1) of this section if instead it were to require all of Participant’s future payments under the plan to be paid instead to Spouse, as an alternate payee (so that payments that would otherwise be paid to the Participant during the Participant’s lifetime are instead to be made to the Spouse during the Participant’s lifetime).

Example (3). Previously assigned benefits. Participant and Spouse divorce, and the administrator of Participant’s 401(k) plan receives a domestic relations order. The administrator determines that the order is a QDRO. The QDRO assigns a portion of Participant’s benefits to Spouse 1 as the alternate payee. Participant marries Spouse 2, and then they divorce. Participant’s 401(k) plan administrator subsequently receives a domestic relations order pertaining to Spouse 2. The order assigns to Spouse 2 a portion of Participant’s 401(k) benefits already assigned to Spouse 1. The second order does not fail to be treated as a QDRO solely because the second order is issued after the plan administrator has determined that an earlier order pertaining to Spouse 1 is a QDRO. The second order, however, would fail to be a QDRO under section 206(d)(3)(D)(iii) and paragraph (d)(1) of this section because it assigns to Spouse 2 all or a portion of Participant’s benefits that are already assigned to Spouse 1 by the prior QDRO.

Example (4). Type or form of benefit. Participant retires and commences benefit payments in the form of a straight life annuity based on the life of Participant, with respect to which Spouse consents to the waiver of the surviving spousal rights provided under the plan and section 205 of ERISA. Participant and Spouse divorce after the annuity starting date and present the plan with a domestic relations order that eliminates the straight life annuity based on Participant’s life and provides for Spouse, as alternate payee, to receive all future benefits in the form of a straight life annuity based on the life of Spouse. The plan does not allow reannuitization with a new annuity starting date, as defined in section 205(b)(2) of ERISA (and as further explained in 26 CFR 1.401(a)-20, Q&A–15(b)). Pursuant to paragraph (c)(1) of this section, the order does not fail to be a QDRO solely because it is issued after the annuity starting date, but the order would fail to be a QDRO under section 206(d)(3)(D)(i) and paragraph (d)(1) of this section because the order requires the plan to provide a type or form of benefit, or any option, not otherwise provided under the plan. However, the order would not fail to be a QDRO under section 206(d)(3)(D)(i) and paragraph (d)(1) of this section if instead it were to require all of Participant’s future payments under the plan to be paid instead to Spouse, as an alternate payee (so that payments that would otherwise be paid to the Participant during the Participant’s lifetime are instead to be made to the Spouse during the Participant’s lifetime).

[75 FR 32850, June 10, 2010] 597
Subpart D—Plan Administration as Related to Benefits

§ 2530.210 Employer or employers maintaining the plan.

(a) General statutory provisions—(1) Eligibility to participate and vesting. Except as otherwise provided in section 202(b) or 203(b)(1) of the Act and sections 410(a)(5), 411(a)(5) and 411(a)(6) of the Code, all years of service with the employer or employers maintaining the plan shall be taken into account for purposes of section 202 of the Act and section 410 of the Code (relating to minimum eligibility standards) and section 203 of the Act and section 411(a) of the Code (relating to minimum vesting standards).

(2) Accrual of benefits. Except as otherwise provided in section 202(b) of the Act and section 410(a)(5) of the Code, all years of participation under the plan must be taken into account for purposes of section 204 of the Act and section 411(b) of the Code (relating to benefit accrual). Section 204(b) of the Act and section 411(b) of the Code require only that periods of actual participation in the plan (e.g., covered service) be taken into account for purposes of benefit accrual.

(b) General rules concerning service to be credited under this section. Section 210 of the Act and sections 413(c), 414(b), and 414(c) of the Code provide rules applicable to sections 202, 203, and 204 of the Act and sections 410, 411(a), and 411(b) of the Code for purposes of determining who is an “employer or employers maintaining the plan” and, accordingly, what service is required to be taken into account in the case of a plan maintained by more than one employer. Paragraphs (c) through (e) of this section set forth the rules for determining service required to be taken into account in the case of a plan or plans maintained by multiple employers, controlled groups of corporations and trades or businesses under common control. Note throughout that every mention of multiple employer plans includes multiemployer plans. See § 2530.210(c)(3). Paragraph (f) of this section sets forth special break in service rules for such plans. Paragraph (g) of this section applies the break in service rules of sections 202(b)(4) and 203(b)(3)(D) of the Act and sections 410(a)(5)(D) and 411(a)(6)(D) of the Code (rule of parity) to such plans.

(c) Multiple employer plans—(1) Eligibility to participate and vesting. A multiple employer plan shall be treated as if all maintaining employers constitute a single employer so long as an employee is employed in either covered service or contiguous noncovered service. Accordingly, except as referred to in paragraph (a)(1) and provided in paragraph (f) of this section, in determining an employee’s service for eligibility to participate and vesting purposes, all covered service with an employer or employers maintaining the plan and all contiguous noncovered service with an employer or employers maintaining the plan shall be taken into account. Thus, for example, if an employee in service covered under a multiple employer plan leaves covered service with one employer maintaining the plan and is employed immediately thereafter in covered service with another employer maintaining the plan, the plan is required to credit all hours of service with both employers for purposes of participation and vesting. If an employee moves from contiguous noncovered to covered service, or from covered service to contiguous noncovered service, with the same employer, the plan is required to credit all hours of service with such employer for purposes of eligibility to participate and vesting.

(2) Benefit accrual. A multiple employer plan shall be treated as if all maintaining employers constitute a single employer so long as an employee is employed in covered service. Accordingly, except as referred to in paragraph (a)(2) and provided in paragraph (f) of this section, in determining a participant’s service for benefit accrual purposes, all covered service with an employer or employers maintaining the plan shall be taken into account.

(3) Definitions. (i) For purposes of this section, the term “multiple employer plan” shall mean a multiemployer plan as defined in section 3(37) of the Act and section 414(f) of the Code or a multiple employer plan within the meaning of sections 413(b) and (c) of the
Code and the regulations issued thereunder. Notwithstanding the preceding sentence, a plan maintained solely by members of the same controlled group of corporations within the meaning of paragraph (d) of this section or by trades or businesses which are under the common control of one person or group of persons within the meaning of paragraph (e) of this section shall not be deemed to be a multiple employer plan for purposes of this section, and such plan is required to apply the rules under this section which are applicable to controlled groups of corporations or commonly controlled trades or businesses respectively.

(ii) For purposes of this section, the term "covered service" shall mean service with an employer or employers maintaining the plan within a job classification or class of employees covered under the plan.

(iii) For purposes of this section the term "noncovered service" shall mean service with an employer or employers maintaining the plan which is not covered service.

(iv)(A) General. For purposes of this section noncovered service shall be deemed "contiguous" if (1) the noncovered service precedes or follows covered service and (2) no quit, discharge, or retirement occurs between such covered service and noncovered service.

(B) Exception. Notwithstanding the preceding paragraph, in the case of a controlled group of corporations within the meaning of paragraph (d) of this section or trades or businesses which are under the common control of one person or group of persons within the meaning of paragraph (e) of this section, any transfer of an employee from one member of the controlled group to another member or from one trade or business under common control to another trade or business under the common control of the same person or group of persons shall result in the period of noncovered service which immediately precedes or follows such transfer being deemed "noncontiguous" for purposes of paragraph (c) of this section.

Assume for purposes of diagram No. 1 that X and Y are both employers who are required to contribute to a multiple employer plan and that neither employer maintains any other plan. Covered service is represented by the shaded segments of the diagram. After completing 1 year of noncovered service, employee A immediately enters covered service with X and completes 4 years of covered service. For purposes of eligibility to participate and vesting, the plan is required to credit employee A with 5 years of service with employer X because his period of service with X includes a period of covered service and a period of contiguous noncovered service. On the other hand, employee B, immediately after completing 2 years of noncovered service with X, enters covered service with Y. Because B quit employment with X, his period of noncovered service with X is not contiguous and, therefore, is not required to be taken into account. In the case of employee C, the plan is required to take into account all service with employers X and Y because employee C is employed in covered service with both employers.

The multiple employer plan rules with respect to noncovered service are illustrated in diagram No. 2. Assume that X and Y are both employers who are required to contribute to a multiple employer plan and that neither employer maintains any other plan. Covered service is represented by the shaded segments of the diagram. Employee E completed 3 years of service with employer X in covered service and then immediately entered noncovered service with X. Because E's noncovered service is contiguous, the plan is required to take into account all service with X for purposes of eligibility to participate and vesting under the multiple employer plan. Employee F does not continue to receive credit. F quit the employment of Y and entered noncovered service with X.
(d) Controlled groups of corporations. (1) With respect to a plan maintained by one or more members of a controlled group of corporations (within the meaning of section 1563(a) of the Code, determined without regard to sections 1563(a)(4) and (e)(3)(C), all employees of such corporations shall be treated as employed by a single employer.

(2) Accordingly, except as referred to in paragraph (a)(1) and provided in paragraph (f) of this section, in determining an employee’s service for eligibility to participate and vesting purposes, all service with any employer which is a member of the controlled group of corporations shall be taken into account. Except as referred to in paragraph (a)(2) and provided in paragraph (f) of this section, in determining a participant’s service for benefit accrual purposes, all service during periods of participation covered under the plan with any employer which is a member of the controlled group of corporations shall be taken into account.

(e) Commonly controlled trades or businesses. With respect to a plan maintained only by one or more trades or businesses (whether or not incorporated) which are under common control within the meaning of section 414(c) of the Code and the regulations issued thereunder, all employees of such trades or businesses shall be treated as employed by a single employer. Accordingly, except as referred to in paragraph (a)(1) and provided in paragraph (f) of this section, in determining an employee’s service for eligibility to participate and vesting purposes, all service with any employer which is under common control shall be taken into account. Except as referred to in paragraph (a)(2) and provided in paragraph (f) of this section, in determining a participant’s service for benefit accrual purposes, all service during periods of participation covered under the plan with any employer which is under common control shall be taken into account.

(f) Special break in service rules. (1) In addition to service which may be disregarded under the statutory provisions referred to in paragraph (a) of this section, a multiple employer plan may disregard noncontiguous non-covered service.

(2) In the case of a plan maintained solely by one or more members of a controlled group of corporations or one or more trades or businesses which are under common control, if one of the maintaining employers is also a participating employer in a multiple employer plan which includes other employers which are not members of the controlled group or commonly controlled trades or businesses, service with such other employer maintaining the multiple employer plan may be disregarded by the controlled group or commonly controlled plan.
Diagram No. 4. (Break in Service Rules.)

Diagram No. 4 illustrates the break in service rules of paragraph (f) of this section. Assume for purposes of diagram No. 4 that employer Z is controlled by employer X but employer Y’s only relation to X and Z is that X, Y, and Z are required to contribute to a multiple employer plan. The multiple employer plan, represented by the shaded segments of the diagram, provides for 100 percent vesting after 10 years. X, Y, and Z maintain no other plans.

Employee G completed 5 years of covered service with employer Y, and then moved to noncovered service with employer Z. G’s noncovered service is noncontiguous (see employee F in diagram No. 2 above), and such service may be disregarded for purposes of the multiple employer plan under the rule in paragraph (f)(1).

Employee H completed 2 years of covered service with employer Y and then entered covered service with employer X for 1 year. The multiple employer plan is required to credit H with 3 years of service. H then entered noncovered service with employer Z. H’s noncovered service is noncontiguous (see employee F in diagram No. 2 above), and such service may be disregarded for purposes of the multiple employer plan under the rule in paragraph (f)(1).

(g) Rule of parity. For purposes of sections 202(b)(4) and 203(b)(3)(D) of the Act and sections 410(a)(5)(D) and 411(a)(6)(D) of the Code, in the case of an employee who is a nonvested participant in employer-derived accrued benefits at the time he incurs a 1-year break in service, years of service completed by such employee before such break are not required to be taken into account if at such time he incurs consecutive 1-year breaks in service which equal or exceed the aggregate number of years of service before such breaks. This is so even though the period of noncontiguous noncovered service with an employer or employers maintaining the plan may subsequently be deemed contiguous as the result of the employee entering covered service with the same employer maintaining the plan and, consequently, such plan may be required to credit such service.

Diagram No. 5. (Rule of Parity)

Assume for purposes of diagram No. 5 that X and Y are both employers who are required to contribute to a multiple employer plan which contains a provision applying the rule of parity. Covered service is represented by the shaded segments of the diagram. The plan has 100% vesting after 10 years. X and Y maintain no other plan.

The multiple employer plan credited employee I with 4 years of service with X when he quit employment with X and entered noncovered service with Y. As a result of 4 years of noncontiguous noncovered service with Y, employee I incurred 4 consecutive 1-year breaks in service, so that the multiple employer plan may disregard his prior service (i.e., the 4 years of service with X).

When employee I entered covered service with Y (as a “new employee”), his 4 years of noncontiguous service with Y became contiguous for purposes of the multiple employer plan. Consequently, after 1 year of covered service with Y, the plan is required to credit employee I with 5 years of service.

(b) Example. Under section 203(b)(1)(C) of the Act and section 411(a)(4)(C) of the Code, service with an employer prior to such employer’s adoption of the plan need not be taken into account. The following example demonstrates that this rule applies even if an employee is employed in contiguous noncovered service. The example is applicable to any plan subject to the rules of this section. However, for purposes of clarity, the example assumes that X and Y are required to contribute to a multiple employer plan.

Assume that employee D completed 3 years of covered service with employer Y as of the date X adopts the plan. Immediately after X’s adoption of the plan D left covered service with Y and D entered covered service with X. His prior covered service with Y is
required to be counted, and D remains a participant.

On the other hand, if D had entered service with X any time prior to X’s adoption of the plan and subsequently was covered by the plan when X adopted it, his prior service with Y must also be counted, unless such service may be disregarded under the break in service rules because the period of service with X before X’s adoption of the plan was equal to or greater than his prior service with Y. For example, if X adopted the plan three years after D began employment with X, and consequently after D had incurred 3 consecutive 1-year breaks in service, his prior service with Y could be disregarded.

(1) COMPREHENSIVE DIAGRAM. (NO. 6)

Assume for purposes of diagram No. 6 that employer Z is controlled by employer X within the meaning of paragraph (d) but employer Y’s only relation to X and Z is that X, Y and Z are required to contribute to a multiple employer plan. The shaded segments represent coverage under the multiple employer plan which contains a provision applying the rule of parity. The dotted segment represents a separate plan maintained by Z. Both plans have 100% vesting after 10 years.

Employee J completed 3 years of service with employer X in covered service with the multiple employer plan. J then entered non-covered service with Y and remained with Y for 1 year, and thereby incurred a 1-year break in service under the multiple employer plan. J then entered covered service with employer Y, thereby causing the noncovered service with Y to become contiguous. Covered service with X and contiguous non-covered and covered service with Y must be taken into account for purposes of the multiple employer plan; accordingly, that plan is required to credit J with a total of 5 years of service.

J then left service with Y and entered non-covered service (with respect to the multiple employer plan) for 5 years and thereby incurred 5 consecutive 1-year break in service for purposes of the multiple employer plan. Consequently, the prior service with X and Y may be disregarded for purposes of the multiple employer plan.

J then entered covered service under the multiple employer plan with Z and completed 1 year of service. Because the 5 years of noncovered service with Z is contiguous with the 1 year of covered service, the multiple employer plan is now required to credit J with 6 years of service for purposes of eligibility to participate and vesting.

For purposes of Z’s controlled group plan (i.e., dotted segment), employee J is entitled to receive credit for 9 years of service. The 3 years of service with X, a member of the controlled group, may not be disregarded under the rule of parity because J incurred only 2 consecutive 1-year breaks in service while employed with Y. When J entered service with Z covered under Z’s controlled group plan, the 3 years of service with X were still required to be credited by the controlled group plan. In addition, J must receive credit for the 5 years of service with Z covered under the controlled group plan. Finally, when J moved to service with Z covered under the multiple employer plan the controlled group plan was required to credit J with an additional year of service.

SUBCHAPTER E [RESERVED]
SUBCHAPTER F—FIDUCIARY RESPONSIBILITY UNDER THE
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2550—RULES AND REGULATIONS FOR FIDUCIARY RESPONSIBILITY

Sec. 2550.401c–1 Definition of “plan assets”—insurance company general accounts.
2550.403a–1 Establishment of trust.
2550.403b–1 Exemptions from trust requirement.
2550.404a–1 Investment duties.
2550.404a–2 Safe harbor for automatic roll-overs to individual retirement plans.
2550.404a–3 Safe harbor for distributions from terminated individual account plans.
2550.404a–4 Selection of annuity providers—safe harbor for individual account plans.
2550.404a–5 Fiduciary requirements for disclosure in participant-directed individual account plans.
2550.404b–1 Maintenance of the indicia of ownership of plan assets outside the jurisdiction of the district courts of the United States.
2550.404c–1 ERISA section 404(c) plans.
2550.404c–5 Fiduciary relief for investments in qualified default investment alternatives.
2550.407a–1 General rule for the acquisition and holding of employer securities and employer real property.
2550.407a–2 Limitation with respect to the acquisition of qualifying employer securities and qualifying employer real property.
2550.407d–5 Definition of the term “qualifying employer security”.
2550.407d–6 Definition of the term “employee stock ownership plan”.
2550.408b–1 General statutory exemption for loans to plan participants and beneficiaries who are parties in interest with respect to the plan.
2550.408b–2 General statutory exemption for services or office space.
2550.408b–3 Loans to Employee Stock Ownership Plans.
2550.408b–4 Statutory exemption for investments in deposits of banks or similar financial institutions.
2550.408b–6 Statutory exemption for ancillary services by a bank or similar financial institution.
2550.408b–19 Statutory exemption for cross-trading of securities.
2550.408c–2 Compensation for services.
2550.408e Statutory exemption for acquisition or sale of qualifying employer securities and for acquisition, sale, or lease of qualifying employer real property.

§ 2550.401c–1 Definition of “plan assets”—insurance company general accounts.

(a) In general. (1) This section describes, in the case where an insurer issues one or more policies to or for the benefit of an employee benefit plan (and such policies are supported by assets of an insurance company’s general account), which assets held by the insurer (other than plan assets held in its separate accounts) constitute plan assets for purposes of Subtitle A, and Parts I and 4 of Subtitle B, of Title I of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) and section 4975 of the Internal Revenue Code (the Code), and provides guidance with respect to the application of Title I of the Act and section 4975 of the Code to the general account assets of insurers.

(2) Generally, when a plan has acquired a Transition Policy (as defined in paragraph (h)(6) of this section), the plan’s assets include the Transition Policy, but do not include any of the underlying assets of the insurer’s general account if the insurer satisfies the requirements of paragraphs (c) through (f) of this section or, if the requirements of paragraphs (c) through (f) were not satisfied, the insurer cures...
§ 2550.401c–1

the non-compliance through satisfaction of the requirements in paragraph (1)(5) of this section.

(3) For purposes of paragraph (a)(2) of this section, a plan’s assets will not include any of the underlying assets of the insurer’s general account if the insurer fails to satisfy the requirements of paragraphs (c) through (f) of this section solely because of the takeover of the insurer’s operations from management as a result of the granting of a petition filed in delinquency proceedings in the State court where the insurer is domiciled.

(b) Approval by fiduciary independent of the issuer—(1) In general. An independent plan fiduciary who has the authority to manage and control the assets of the plan must expressly authorize the acquisition or purchase of the Transition Policy. For purposes of this paragraph, a fiduciary is not independent if the fiduciary is an affiliate of the insurer issuing the policy.

(2) Notwithstanding paragraph (b)(1) of this section, the authorization by an independent plan fiduciary is not required if:

(i) The insurer is the employer maintaining the plan, or a party in interest which is wholly owned by the employer maintaining the plan; and

(ii) The requirements of section 408(b)(5) of the Act are met.1

(c) Duty of disclosure—(1) In general. An insurer shall furnish the information described in paragraphs (c)(3) and (c)(4) of this section to a plan fiduciary acting on behalf of a plan to which a Transition Policy has been issued. Paragraph (c)(2) of this section describes the style and format of such disclosure. Paragraph (c)(3) of this section describes the content of the initial disclosure. Paragraph (c)(4) of this section describes the information that must be disclosed by the insurer at least once per year for as long as the Transition Policy remains outstanding.1

1The Department notes that, because section 401(c)(1)(D) of the Act and the definition of Transition Policy preclude the issuance of any additional Transition Policies after December 31, 1998, the requirement for independent fiduciary authorization of the acquisition or purchase of the Transition Policy in paragraph (b) no longer has any application.

(2) Style and format. The disclosure required by this paragraph should be clear and concise and written in a manner calculated to be understood by a plan fiduciary, without relinquishing any of the substantive detail required by paragraphs (c)(3) and (c)(4) of this section. The information does not have to be organized in any particular order but should be presented in a manner which makes it easy to understand the operation of the Transition Policy.

(3) Initial disclosure. The insurer must provide to the plan, either as part of an amended policy, or as a separate written document, the disclosure information set forth in paragraphs (c)(3)(i) through (iv) of this section. The disclosure must include all of the following information which is applicable to the Transition Policy:

(A) A description of the method by which any income and any expense of the insurer’s general account are allocated to the policy during the term of the policy and upon its termination, including:

(B) A description of the method used by the insurer to determine the fees, charges, expenses or other amounts that are, or may be, assessed against the policyholder or deducted by the insurer from any accumulation fund under the policy, including the extent and frequency with which such fees, charges, expenses or other amounts may be modified by the insurance company;

(B) A description of the method by which the insurer determines the return to be credited to any accumulation fund under the policy, including a description of the method used to allocate income and expenses to lines of business, business segments, and policies within such lines of business and business segments, and a description of how any withdrawals, transfers, or payments will affect the amount of the return credited;

(C) A description of the rights which the policyholder or plan participants have to withdraw or transfer all or a portion of any accumulation fund under the policy, or to apply the amount of a withdrawal to the purchase of guaranteed benefits or to the payment of benefits, and the terms on
which such withdrawals or other applications of funds may be made, including a description of any charges, fees, credits, market value adjustments, or any other charges or adjustments, both positive and negative;

(D) A statement of the method used to calculate any charges, fees, credits or market value adjustments described in paragraph (c)(3)(i)(C) of this section, and, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request:

(1) The formula actually used to calculate the market value adjustment, if any, to be applied to the unallocated amount in the accumulation fund upon distribution of a lump sum payment to the policyholder, and

(2) The actual calculation, as of a specified date that is no earlier than the last contract anniversary preceding the date of the request, of the applicable market value adjustment, including a description of the specific variables used in the calculation, the value of each of the variables, and a general description of how the value of each of those variables was determined.

(3) If the formula is based on interest rate guarantees applicable to new contracts of the same class or classes, and the duration of the assets underlying the accumulation fund, the contract must describe the process by which those components are ascertained or obtained. If the formula is based on an interest rate implicit in an index of publicly traded obligations, the identity of the index, the manner in which it is used, and identification of the source or publication where any data used in the formula can be found, must be disclosed;

(ii) A statement describing the expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer’s right, if any, to modify or eliminate such guarantees;

(iii) A description of the rights of the parties to make or discontinue contributions under the policy, and of any restrictions (such as timing, minimum or maximum amounts, and penalties and grace periods for late payments) on the making of contributions under the policy, and the consequences of the discontinuance of contributions under the policy; and

(iv) A statement of how any policyholder or participant-initiated withdrawals are to be made: first-in, first-out (FIFO) basis, last-in, first-out (LIFO) basis, pro rata or another basis.

(4) Annual disclosure. At least annually and not later than 90 days following the period to which it relates, an insurer shall provide the following information to each plan to which a Transition Policy has been issued:

(i) The balance of any accumulation fund on the first day and last day of the period covered by the annual report;

(ii) Any deposits made to the accumulation fund during such annual period;

(iii) An itemized statement of all income attributed to the policy or added to the accumulation fund during the period, and a description of the method used by the insurer to determine the precise amount of income;

(iv) The actual rate of return credited to the accumulation fund under the policy during such period, stating whether the rate of return was calculated before or after deduction of expenses charged to the accumulation fund;

(v) Any other additions to the accumulation fund during such period;

(vi) An itemized statement of all fees, charges, expenses or other amounts assessed against the policy or deducted from the accumulation fund during the reporting year, and a description of the method used by the insurer to determine the precise amount of the fees, charges and other expenses;

(vii) An itemized statement of all benefits paid, including annuity purchases, to participants and beneficiaries from the accumulation fund;

(viii) The dates on which the additions or subtractions were credited to, or deducted from, the accumulation fund during such period;

(ix) A description, if applicable, of all transactions with affiliates which exceed 1 percent of group annuity reserves of the general account for the prior reporting year;

(x) A statement describing any expense, income and benefit guarantees
under the policy, including a description of the length of such guarantees, and of the insurer’s right, if any, to modify or eliminate such guarantees. However, the information on guarantees does not have to be provided annually if it was previously disclosed in the insurance policy and has not been modified since that time;

(x) A good faith estimate of the amount that would be payable in a lump sum at the end of such period pursuant to the request of a policyholder for payment or transfer of amounts in the accumulation fund under the policy after the insurer deducts any applicable charges and makes any appropriate market value adjustments, upward or downward, under the terms of the policy. However, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request the information contained in paragraph (c)(3)(i)(D) as of a specified date that is no earlier than the last contract anniversary preceding the date of the request; and

(xii) An explanation that the insurer will make available promptly upon request of a plan, copies of the following publicly available financial data or other publicly available reports relating to the financial condition of the insurer:

(A) National Association of Insurance Commissioners Statutory Annual Statement, with Exhibits, General Interrogatories, and Schedule D, Part 1A, Sections 1 and 2 and Schedule S—Part 3E;

(B) Rating agency reports on the financial strength and claims-paying ability of the insurer;

(C) Risk adjusted capital ratio, with a brief description of its derivation and significance, referring to the risk characteristics of both the assets and the liabilities of the insurer;

(D) Actuarial opinion of the insurer’s Appointed Actuary certifying the adequacy of the insurer’s reserves as required by New York State Insurance Department Regulation 126 and comparable regulations of other States; and

(E) The insurer’s most recent SEC Form 10K and Form 10Q (stock companies only).

(d) Alternative separate account arrangements—(1) In general. An insurer must provide the plan fiduciary with the following additional information at the same time as the initial disclosure required under paragraph (c)(3) of this section:

(i) A statement explaining the extent to which alternative contract arrangements supported by assets of separate accounts of insurers are available to plans;

(ii) A statement as to whether there is a right under the policy to transfer funds to a separate account and the terms governing any such right; and

(iii) A statement explaining the extent to which general account contracts and separate account contracts of the insurer may pose differing risks to the plan.

(2) An insurer will be deemed to comply with the requirements of paragraph (d)(1)(iii) of this section if the disclosure provided to the plan includes the following statement:

a. Contractual arrangements supported by assets of separate accounts may pose differing risks to plans from contractual arrangements supported by assets of general accounts. Under a general account contract, the plan’s contributions or premiums are placed in the insurer’s general account and commingled with the insurer’s corporate funds and assets (excluding separate accounts and special deposit funds). The insurance company combines in its general account premiums received from all of its lines of business. These premiums are pooled and invested by the insurer. General account assets in the aggregate support the insurer’s obligations under all of its insurance contracts, including (but not limited to) its individual and group life, health, disability, and annuity contracts. Experience rated general account policies may share in the experience of the general account through interest credits, dividends, or rate adjustments, but assets in the general account are not segregated for the exclusive benefit of any particular policy or obligation. General account assets are also available to the insurer for the conduct of its routine business activities, such as the payment of salaries,
rent, other ordinary business expenses and dividends.

b. An insurance company separate account is a segregated fund which is not commingled with the insurer’s general assets. Depending on the particular terms of the separate account contract, income, expenses, gains and losses associated with the assets allocated to a separate account may be credited to or charged against the separate account without regard to other income, expenses, gains, or losses of the insurance company, and the investment results passed through directly to the policyholders. While most, if not all, general account investments are maintained at book value, separate account investments are normally maintained at market value, which can fluctuate according to market conditions. In large measure, the risks associated with a separate account contract depend on the particular assets in the separate account.

c. The plan’s legal rights vary under general and separate account contracts. In general, an insurer is subject to ERISA’s fiduciary responsibility provisions with respect to the assets of a separate account (other than a separate account registered under the Investment Company Act of 1940) to the extent that the investment performance of such assets is passed directly through to the plan policyholders. ERISA requires insurers, in administering separate account assets, to act solely in the interest of the plan’s participants and beneficiaries; prohibits self-dealing and conflicts of interest; and requires insurers to adhere to a prudent standard of care. In contrast, ERISA generally imposes less stringent standards in the administration of general account contracts which were issued on or before December 31, 1998.

d. On the other hand, State insurance regulation is typically more restrictive with respect to general accounts than separate accounts. However, State insurance regulation may not provide the same level of protection to plan policyholders as ERISA regulation. In addition, insurance company general account policies often include various guarantees under which the insurer assumes risks relating to the funding and distribution of benefits. Insurers do not usually provide any guarantees with respect to the investment returns on assets held in separate accounts. Of course, the extent of any guarantees from any general account or separate account contract will depend upon the specific policy terms.

e. Finally, separate accounts and general accounts pose differing risks in the event of the insurer’s insolvency. In the event of insolvency, funds in the general account are available to meet the claims of the insurer’s general creditors, after payment of amounts due under certain priority claims, including amounts owed to its policyholders. Funds held in a separate account as reserves for its policy obligations, however, may be protected from the claims of creditors other than the policyholders participating in the separate account. Whether separate account funds will be granted this protection will depend upon the terms of the applicable policies and the provisions of any applicable laws in effect at the time of insolvency.

(e) Termination procedures. Within 90 days of written notice by a policyholder to an insurer, the insurer must permit the policyholder to exercise the right to terminate or discontinue the policy and to elect to receive without penalty either:

(1) A lump sum payment representing all unallocated amounts in the accumulation fund. For purposes of this paragraph (e)(1), the term penalty does not include a market value adjustment (as defined in paragraph (h)(7) of this section) or the recovery of costs actually incurred which would have been recovered by the insurer but for the termination or discontinuance of the policy, including any unliquidated acquisition expenses, to the extent not previously recovered by the insurer; or

(2) A book value payment of all unallocated amounts in the accumulation fund under the policy in approximately equal annual installments, over a period of no longer than 10 years, together with interest computed at an annual rate which is no less than the annual rate which was credited to the accumulation fund under the policy as of the date of the contract termination or discontinuance, minus 1 percentage point. Notwithstanding paragraphs
(e)(1) and (e)(2) of this section, the insurer may defer, for a period not to exceed 180 days, amounts required to be paid to a policyholder under this paragraph for any period of time during which regular banking activities are suspended by State or federal authorities, a national securities exchange is closed for trading (except for normal holiday closings), or the Securities and Exchange Commission has determined that a state of emergency exists which may make such determination and payment impractical.

(f) **Insurer-initiated amendments.** In the event the insurer makes an insurer-initiated amendment (as defined in paragraph (h)(8) of this section), the insurer must provide written notice to the plan at least 60 days prior to the effective date of the insurer-initiated amendment. The notice must contain a complete description of the amendment and must inform the plan of its right to terminate or discontinue the policy and withdraw all unallocated funds without penalty by sending a written request within such 60 day period to the name and address contained in the notice. The plan must be offered the election to receive either a lump sum or an installment payment as described in paragraph (e)(1) and (e)(2) of this section. An insurer-initiated amendment shall not apply to a contract if the plan fiduciary exercises its right to terminate or discontinue the contract within such 60 day period and to receive a lump sum or installment payment.

(g) **Prudence.** An insurer shall manage those assets of the insurer which are assets of such insurer’s general account (irrespective of whether any such assets are plan assets) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, taking into account all obligations supported by such enterprise. This prudence standard applies to the conduct of all insurers with respect to policies issued to plans on or before December 31, 1998, and differs from the prudence standard set forth in section 404(a)(1)(B) of the Act. Under the prudence standard provided in this paragraph, prudence must be determined by reference to all of the obligations supported by the general account, not just the obligations owed to plan policyholders. The more stringent standard of prudence set forth in section 404(a)(1)(B) of the Act continues to apply to any obligations which insurers may have as fiduciaries which do not arise from the management of general account assets, as well as to insurers’ management of plan assets maintained in separate accounts. The terms of this section do not modify or reduce the fiduciary obligations applicable to insurers in connection with policies issued after December 31, 1998, which are supported by general account assets, including the standard of prudence under section 404(a)(1)(B) of the Act.

(h) **Definitions.** For purposes of this section:

(i) An **affiliate** of an insurer means:

(ii) Any person, directly or indirectly, through one or more intermediaries, controlling, controlled by, or under common control with the insurer.

(iii) Any officer of, director of, 5 percent or more partner in, or highly compensated employee (earning 5 percent or more of the yearly wages of the insurer) of, such insurer or of any person described in paragraph (h)(1)(i) of this section including in the case of an insurer, an insurance agent or broker thereof (whether or not such person is a common law employee) if such agent or broker is an employee described in this paragraph or if the gross income received by such agent or broker from such insurer exceeds 5 percent of such agent’s gross income from all sources for the year, and

(iv) Any corporation, partnership, or unincorporated enterprise of which a person described in paragraph (h)(1)(ii) of this section is an officer, director, or a 5 percent or more partner.

(2) The term **control** means the power to exercise a controlling influence over the management or policies of a person other than an individual.

(3) The term **guaranteed benefit policy** means a policy described in section 401(b)(2)(B) of the Act and any regulations promulgated thereunder.
(4) The term *insurer* means an insurer as described in section 401(b)(2)(A) of the Act.

(5) The term *accumulation fund* means the aggregate net considerations (i.e., gross considerations less all deductions from such considerations) credited to the Transition Policy plus all additional amounts, including interest and dividends, credited to such Transition Policy less partial withdrawals, benefit payments and less all charges and fees imposed against this accumulated amount under the Transition Policy other than surrender charges and market value adjustments.

(6) The term *Transition Policy* means:

(i) A policy or contract of insurance (other than a guaranteed benefit policy) that is issued by an insurer to, or on behalf of, an employee benefit plan on or before December 31, 1998, and which is supported by the assets of the insurer's general account.

(ii) A policy will not fail to be a Transition Policy merely because the policy is amended or modified:

(A) To comply with the requirements of section 401(c) of the Act and this section; or

(B) Pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (e.g., shares of stock or policy credits).

(7) For purposes of this section, the term *market value adjustment* means an adjustment to the book value of the accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under the policy. An adjustment is a market value adjustment within the meaning of this definition only if the insurer has determined the amount of the adjustment pursuant to a method which was previously disclosed to the policyholder in accordance with paragraph (c)(3)(i)(D) of this section, and the method permits both upward and downward adjustments to the book value of the accumulation fund.

(8) The term *insurer-initiated amendment* is defined in paragraphs (b)(8)(i), (ii) and (iii) of this section as:

(i) An amendment to a Transition Policy made by an insurer pursuant to a unilateral right to amend the policy terms that would have a material adverse effect on the policyholder; or

(ii) Any of the following unilateral changes in the insurer's conduct or practices with respect to the policyholder or the accumulation fund under the policy that result in a material reduction of existing or future benefits under the policy, a material reduction in the value of the policy or a material increase in the cost of financing the plan or plan benefits:

(A) A change in the methodology for assessing fees, expenses, or other charges against the accumulation fund or the policyholder;

(B) A change in the methodology used for allocating income between lines of business, or product classes within a line of business;

(C) A change in the methodology used for determining the rate of return to be credited to the accumulation fund under the policy;

(D) A change in the methodology used for determining the amount of any fees, charges, expenses, or market value adjustments applicable to the accumulation fund under the policy in connection with the termination of the contract or withdrawal from the accumulation fund;

(E) A change in the dividend class to which the policy or contract is assigned;

(F) A change in the policyholder's rights in connection with the termination of the policy, withdrawal of funds or the purchase of annuities for plan participants; and

(G) A change in the annuity purchase rates guaranteed under the terms of the contract or policy, unless the new rates are more favorable for the policyholder.

(iii) For purposes of this definition, an insurer-initiated amendment is material if a prudent fiduciary could reasonably conclude that the amendment should be considered in determining
how or whether to exercise any rights with respect to the policy, including termination rights.

(iv) For purposes of this definition, the following amendments or changes are not insurer-initiated amendments:

(A) Any amendment or change which is made with the affirmative consent of the policyholder;

(B) Any amendment or change which is made in order to comply with the requirements of section 401(c) of the Act and this section; or

(C) Any amendment or change which is made pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (e.g., shares of stock or policy credits).

(i) Limitation on liability. (1) No person shall be subject to liability under Parts 1 and 4 of Title I of the Act or section 4975 of the Internal Revenue Code of 1986 for conduct which occurred prior to the applicability dates of the regulation on the basis of a claim that the assets of an insurer (other than plan assets held in a separate account) constitute plan assets. Notwithstanding the provisions of this paragraph (i)(1), this section shall not:

(i) Apply to an action brought by the Secretary of Labor pursuant to paragraphs (2) or (5) of section 502(a) of ERISA for a breach of fiduciary responsibility which would also constitute a violation of Federal or State criminal law;

(ii) Preclude the application of any Federal criminal law; or

(iii) Apply to any civil action commenced before November 7, 1995.

(2) Nothing in this section relieves any person from any State law regulating insurance which imposes additional obligations or duties upon insurers to the extent not inconsistent with the provisions of this section. Therefore, nothing in this section should be construed to preclude a State from requiring insurers to make additional disclosures to policyholders, including plans. Nor does this section prohibit a State from imposing additional substantive requirements with respect to the management of general accounts or from otherwise regulating the relationship between the policyholder and the insurer to the extent not inconsistent with the provisions of this section.

(3) Nothing in this section precludes any claim against an insurer or other person for violations of the Act which do not require a finding that the underlying assets of a general account constitute plan assets, regardless of whether the violation relates to a Transition Policy.

(4) If the requirements in paragraphs (c) through (f) of this section are not met with respect to a plan that has purchased or acquired a Transition Policy, and the insurer has not cured the non-compliance through satisfaction of the requirements in paragraph (i)(5) of this section, the plan's assets include an undivided interest in the underlying assets of the insurer's general account for that period of time for which the requirements are not met. However, an insurer's failure to comply with the requirements of this section with respect to any particular Transition Policy will not result in the underlying assets of the general account constituting plan assets with respect to other Transition Policies if the insurer is otherwise in compliance with the requirements contained in this section.

(5) Notwithstanding paragraphs (a)(2) and (i)(4) of this section, a plan's assets will not include an undivided interest in the underlying assets of the insurer's general account if the insurer made reasonable and good faith attempts at compliance with each of the requirements of paragraphs (c) through (f) of this section, and meets each of the following conditions:

(i) The insurer has in place written procedures that are reasonably designed to assure compliance with the requirements of paragraphs (c) through (f) of this section, including procedures reasonably designed to detect any instances of non-compliance.

(ii) No later than 60 days following the earlier of the insurer's detection of an instance of non-compliance or the
receipt of written notice of non-compliance from the plan, the insurer complies with the requirements of paragraphs (c) through (f) of this section. If the insurer has failed to pay a plan the amounts required under paragraphs (e) or (f) of this section within 90 days of receiving written notice of termination or discontinuance of the policy, the insurer must make all corrections and adjustments necessary to restore to the plan the full amounts that the plan would have received but for the insurer’s non-compliance within the applicable 60 day period; and

(iii) The insurer makes the plan whole for any losses resulting from the non-compliance as follows:

(A) If the insurer has failed to comply with the disclosure or notice requirements set forth in paragraphs (c), (d) and (f) of this section, then the insurer must make the plan whole for any losses resulting from its non-compliance within the earlier of 60 days of detection by the insurer or sixty days following the receipt of written notice from the plan; and

(B) If the insurer has failed to pay a plan any amounts required under paragraphs (e) or (f) of this section within 90 days of receiving written notice of termination or discontinuance of the policy, the insurer must pay to the plan interest on any amounts restored pursuant to paragraph (i)(5)(ii) of this section at the “underpayment rate” as set forth in 26 U.S.C. sections 6621 and 6622. Such interest must be paid within the earlier of 60 days of detection by the insurer or sixty days following receipt of written notice of non-compliance from the plan.

(i) Applicability dates—(1) In general. Except as provided in paragraphs (j)(2) through (4) of this section, this section is applicable on July 5, 2001.

(2) Paragraph (c) relating to initial disclosures and paragraph (d) relating to separate account disclosures are applicable on July 5, 2000.

(3) The first annual disclosure required under paragraph (c)(4) of this section shall be provided to each plan not later than 18 months following January 5, 2000.

(4) Paragraph (f), relating to insurer-initiated amendments, is applicable on January 5, 2000.

(k) Effective date. This section is effective January 5, 2000.

[65 FR 639, Jan. 5, 2000]

§ 2550.403a-1 Establishment of trust.

(a) In general. Except as otherwise provided in §403b–1, all assets of an employee benefit plan shall be held in trust by one or more trustees pursuant to a written trust instrument.

(b) Specific applications. (1) The requirements of paragraph (a) of this section will not fail to be satisfied merely because securities of a plan are held in the name of a nominee or in street name, provided such securities are held on behalf of the plan by:

(i) A bank or trust company that is subject to supervision by the United States or a State, or a nominee of such bank or trust company;

(ii) A broker or dealer registered under the Securities Exchange Act of 1934, or a nominee of such broker or dealer; or

(iii) A “clearing agency,” as defined in section 3(a)(23) of the Securities Exchange Act of 1934, or its nominee.

(2) Where a corporation described in section 501(c)(2) of the Internal Revenue Code holds property on behalf of a plan, the requirements of paragraph (a) of this section are satisfied with respect to such property if all the stock of such corporation is held in trust on behalf of the plan by one or more trustees.

(3) If the assets of an entity in which a plan invests include plan assets by reason of the plan’s investment in the entity, the requirements of paragraph (a) of this section are satisfied with respect to such investment if the indicia of ownership of the plan’s interest in the entity are held in trust on behalf of the plan by one or more trustees.

(c) Requirements concerning trustees. The trustee or trustees referred to in paragraphs (a) and (b) shall be either named in the trust instrument or in the plan instrument described in section 402(a) of the Act, or appointed by a person who is a named fiduciary (within the meaning of section 402(a)(2) of the Act). Upon acceptance of being named or appointed, the trustee or trustees shall have exclusive authority and discretion to manage and control

611
§ 2550.403b–1 Exemptions from trust requirement.

(a) Statutory exemptions. The requirements of section 403(a) of the Act and section 403a–1 shall not apply—

(1) To any assets of a plan which consist of insurance contracts or policies issued by an insurance company qualified to do business in a State;

(2) To any assets of such an insurance company or any assets of a plan which are held by such an insurance company;

(3) To a plan—

(i) Some or all of the participants of which are employees described in section 401(c)(1) of the Internal Revenue Code of 1954; or

(ii) Which consists of one or more individual retirement accounts described in section 408 of the Internal Revenue Code of 1954. To the extent that such plan’s assets are held in one or more custodial accounts which qualify under section 408(f) or 408(h) of such Code, whichever is applicable;

(4) To a contract established and maintained under section 403(b) of the Internal Revenue Code of 1954 to the extent that the assets of the contract are held in one or more custodial accounts pursuant to section 403(b)(7) of such Code.

(5) To any plan, fund or program under which an employer, all of whose stock is directly or indirectly owned by employees, former employees or their beneficiaries, proposes through an unfunded arrangement to compensate retired employees for benefits which were forfeited by such employees under a pension plan maintained by a former employer prior to the date such pension plan became subject to the Act.

[47 FR 21247, May 18, 1982]

§ 2550.404a–1 Investment duties.

(a) In general. Section 404(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (the Act) provides, in part, that a fiduciary shall discharge his duties with respect to a plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

(b) Investment duties. (1) With regard to an investment or investment course of action taken by a fiduciary of an employee benefit plan pursuant to his investment duties, the requirements of section 404(a)(1)(B) of the Act set forth in subsection (a) of this section are satisfied if the fiduciary:

(i) Has given appropriate consideration to those facts and circumstances that, given the scope of such fiduciary’s investment duties, the fiduciary knows or should know are relevant to the particular investment or investment course of action involved, including the role the investment or investment course of action plays in that portion of the plan’s investment portfolio with respect to which the fiduciary has investment duties; and

(ii) Has acted accordingly.

(2) For purposes of paragraph (b)(1) of this section, “appropriate consideration” shall include, but is not necessarily limited to,

(i) A determination by the fiduciary that the particular investment or investment course of action is reasonably designed, as part of the portfolio (or, where applicable, that portion of the plan portfolio with respect to which the fiduciary has investment duties), to further the purposes of the plan, taking into consideration the risk of loss and the opportunity for gain (or other return) associated with the investment or investment course of action, and
(ii) Consideration of the following factors as they relate to such portion of the portfolio:

(A) The composition of the portfolio with regard to diversification;

(B) The liquidity and current return of the portfolio relative to the anticipated cash flow requirements of the plan; and

(C) The projected return of the portfolio relative to the funding objectives of the plan.

(3) An investment manager appointed, pursuant to the provisions of section 402(c)(3) of the Act, to manage all or part of the assets of a plan, may, for purposes of compliance with the provisions of paragraphs (b)(1) and (2) of this section, rely on, and act upon the basis of, information pertaining to the plan provided by or at the direction of the appointing fiduciary, if—

(i) Such information is provided for the stated purpose of assisting the manager in the performance of his investment duties, and

(ii) The manager does not know and has no reason to know that the information is incorrect.

(c) Definitions. For purposes of this section:

(1) The term investment duties means any duties imposed upon, or assumed or undertaken by, a person in connection with the investment of plan assets which make or will make such person a fiduciary of an employee benefit plan or which are performed by such person as a fiduciary of an employee benefit plan as defined in section 3(21)(A)(i) or (ii) of the Act.

(2) The term investment course of action means any series or program of investments or actions related to a fiduciary’s performance of his investment duties.

(3) The term plan means an employee benefit plan to which title I of the Act applies.

[44 FR 37225, June 26, 1979]

§ 2550.404a–2 Safe harbor for automatic rollovers to individual retirement plans.

(a) In general. (1) Pursuant to section 657(c) of the Economic Growth and Tax Relief Reconciliation Act of 2001, Public Law 107-16, June 7, 2001, 115 Stat. 38, this section provides a safe harbor under which a fiduciary of an employee pension benefit plan subject to Title I of the Employee Retirement Income Security Act of 1974, as amended (the Act), 29 U.S.C. 1001 et seq., will be deemed to have satisfied his or her fiduciary duties under section 404(a) of the Act in connection with an automatic rollover of a mandatory distribution described in section 401(a)(31)(B) of the Internal Revenue Code of 1986, as amended (the Code). This section also provides a safe harbor for certain other mandatory distributions not described in section 401(a)(31)(B) of the Code.

(2) The standards set forth in this section apply solely for purposes of determining whether a fiduciary meets the requirements of this safe harbor. Such standards are not intended to be the exclusive means by which a fiduciary might satisfy his or her responsibilities under the Act with respect to rollovers of mandatory distributions described in paragraphs (c) and (d) of this section.

(b) Safe harbor. A fiduciary that meets the conditions of paragraph (c) or paragraph (d) of this section is deemed to have satisfied his or her duties under section 404(a) of the Act with respect to both the selection of an individual retirement plan provider and the investment of funds in connection with the rollover of mandatory distributions described in those paragraphs to an individual retirement plan, within the meaning of section 7701(a)(37) of the Code.

(c) Conditions. With respect to an automatic rollover of a mandatory distribution described in section 401(a)(31)(B) of the Code, a fiduciary shall qualify for the safe harbor described in paragraph (b) of this section if:

(1) The present value of the nonforfeitable accrued benefit, as determined under section 411(a)(11) of the Code, does not exceed the maximum amount under section 401(a)(31)(B) of the Code;

(2) The mandatory distribution is to an individual retirement plan within the meaning of section 7701(a)(37) of the Code;

(3) In connection with the distribution of rolled-over funds to an individual retirement plan, the fiduciary
enters into a written agreement with an individual retirement plan provider that provides:

(i) The rolled-over funds shall be invested in an investment product designed to preserve principal and provide a reasonable rate of return, whether or not such return is guaranteed, consistent with liquidity;

(ii) For purposes of paragraph (c)(3)(i) of this section, the investment product selected for the rolled-over funds shall seek to maintain, over the term of the investment, the dollar value that is equal to the amount invested in the product by the individual retirement plan;

(iii) The investment product selected for the rolled-over funds shall be offered by a state or federally regulated financial institution, which shall be: A bank or savings association, the deposits of which are insured by the Federal Deposit Insurance Corporation; a credit union, the member accounts of which are insured within the meaning of section 101(7) of the Federal Credit Union Act; an insurance company, the products of which are protected by State guaranty associations; or an investment company registered under the Investment Company Act of 1940;

(iv) All fees and expenses attendant to an individual retirement plan, including investments of such plan, (e.g., establishment charges, maintenance fees, investment expenses, termination costs and surrender charges) shall not exceed the fees and expenses charged by the individual retirement plan provider and the fees and expenses attendant to the individual retirement plan provider and the fees and expenses attendant to the individual retirement plan; and

(5) Both the fiduciary’s selection of an individual retirement plan and the investment of funds would not result in a prohibited transaction under section 406 of the Act, unless such actions are exempted from the prohibited transaction provisions by a prohibited transaction exemption issued pursuant to section 408(a) of the Act.

(d) Mandatory distributions of $1,000 or less. A fiduciary shall qualify for the protection afforded by the safe harbor described in paragraph (b) of this section with respect to a mandatory distribution of one thousand dollars ($1,000) or less described in section 411(a)(11) of the Code, provided there is no affirmative distribution election by the participant and the fiduciary makes a rollover distribution of such amount into an individual retirement plan on behalf of such participant in accordance with the provisions of section 401(a)(31)(B) of the Code; and

(e) Effective date. This section shall be effective and shall apply to any rollover of a mandatory distribution made on or after March 28, 2005.

[69 FR 58028, Sept. 28, 2004]
§ 2550.404a-3 Safe harbor for distributions from terminated individual account plans.

(a) General. (1) This section provides a safe harbor under which a fiduciary (including a qualified termination administrator, within the meaning of § 2578.1(g) of this chapter) of a terminated individual account plan, as described in paragraph (a)(2) of this section, will be deemed to have satisfied its duties under section 404(a) of the Employee Retirement Income Security Act of 1974, as amended (the Act), 29 U.S.C. 1001 et seq., in connection with a distribution described in paragraph (b) of this section.

(2) This section shall apply to an individual account plan only if—

(i) In the case of an individual account plan that is an abandoned plan within the meaning of § 2578.1 of this chapter, such plan was intended to be maintained as a tax-qualified plan in accordance with the requirements of section 401(a), 403(a), or 403(b) of the Internal Revenue Code of 1986 (Code); or

(ii) In the case of any other individual account plan, such plan is maintained in accordance with the requirements of section 401(a), 403(a), or 403(b) of the Code at the time of the distribution.

(3) The standards set forth in this section apply solely for purposes of determining whether a fiduciary meets the requirements of this safe harbor. Such standards are not intended to be the exclusive means by which a fiduciary might satisfy his or her responsibilities under the Act with respect to making distributions described in this section.

(b) Distributions. This section shall apply to a distribution from a terminated individual account plan if, in connection with such distribution:

(1) The participant or beneficiary, on whose behalf the distribution will be made, was furnished notice in accordance with paragraph (e) of this section or, in the case of an abandoned plan, § 2578.1(d)(2)(vi) of this chapter, and

(2) The participant or beneficiary failed to elect a form of distribution within 30 days of the furnishing of the notice described paragraph (b)(1) of this section.

(c) Safe harbor. A fiduciary that meets the conditions of paragraph (d) of this section shall, with respect to a distribution described in paragraph (b) of this section, be deemed to have satisfied its duties under section 404(a) of the Act with respect to the distribution of benefits, selection of a transferee entity described in paragraph (d)(1)(i) through (iii) of this section, and the investment of funds in connection with the distribution.

(d) Conditions. A fiduciary shall qualify for the safe harbor described in paragraph (c) of this section if:

(1) The distribution described in paragraph (b) of this section is made—

(i) To an individual retirement plan within the meaning of section 7701(a)(37) of the Code;

(ii) In the case of a distribution on behalf of a designated beneficiary (as defined by section 401(a)(9)(E) of the Code) who is not the surviving spouse of the deceased participant, to an inherited individual retirement plan (within the meaning of section 402(c)(11) of the Code) established to receive the distribution on behalf of the nonspouse beneficiary;

(iii) In the case of a distribution by a qualified termination administrator with respect to which the amount to be distributed is $1000 or less and that amount is less than the minimum amount required to be invested in an individual retirement plan product offered by the qualified termination administrator to the public at the time of the distribution, to:

(A) An interest-bearing federally insured bank or savings association account in the name of the participant or beneficiary;

(B) The unclaimed property fund of the State in which the participant’s or beneficiary’s last known address is located, or

(C) An individual retirement plan (described in paragraph (d)(1)(i) or (d)(1)(ii) of this section) offered by a financial institution other than the qualified termination administrator to the public at the time of the distribution.

(2) Except with respect to distributions to State unclaimed property funds (described in paragraph
(d)(1)(iii)(B) of this section), the fiduciary enters into a written agreement with the transferee entity which provides:

(i) The distributed funds shall be invested in an investment product designed to preserve principal and provide a reasonable rate of return, whether or not such return is guaranteed, consistent with liquidity (except that distributions under paragraph (d)(1)(iii)(A) of this section to a bank or savings account are not required to be invested in such a product);

(ii) For purposes of paragraph (d)(2)(i) of this section, the investment product shall—

(A) Seek to maintain, over the term of the investment, the dollar value that is equal to the amount invested in the product by the individual retirement plan (described in paragraph (d)(1)(i) or (d)(1)(ii) of this section), and

(B) Be offered by a State or federally regulated financial institution, which shall be: a bank or savings association, the deposits of which are insured by the Federal Deposit Insurance Corporation; a credit union, the member accounts of which are insured within the meaning of section 101(7) of the Federal Credit Union Act; an insurance company, the products of which are protected by State guaranty associations; or an investment company registered under the Investment Company Act of 1940;

(iii) All fees and expenses attendant to the transferee plan (described in paragraph (d)(1)(i) or (d)(1)(ii) of this section) or account (described in paragraph (d)(1)(iii)(A) of this section), including investments of such plan, (e.g., establishment charges, maintenance fees, investment expenses, termination costs and surrender charges), shall not exceed the fees and expenses charged by the provider of the plan or account for comparable plans or accounts established for reasons other than the receipt of a distribution under this section; and

(iv) The participant or beneficiary on whose behalf the fiduciary makes a distribution shall have the right to enforce the terms of the contractual agreement establishing the plan (described in paragraph (d)(1)(i) or (d)(1)(ii) of this section) or account (described in paragraph (d)(1)(iii)(A) of this section), with regard to his or her transferred account balance, against the plan or account provider.

(3) Both the fiduciary’s selection of a transferee plan (described in paragraph (d)(1)(i) or (d)(1)(ii) of this section) or account (described in paragraph (d)(1)(iii)(A) of this section) and the investment of funds would not result in a prohibited transaction under section 406 of the Act, unless such actions are exempted from the prohibited transaction provisions by a prohibited transaction exemption issued pursuant to section 408(a) of the Act.

(e) Notice to participants and beneficiaries—(1) Content. Each participant or beneficiary of the plan shall be furnished a notice written in a manner calculated to be understood by the average plan participant and containing the following:

(i) The name of the plan;

(ii) A statement of the account balance, the date on which the amount was calculated, and, if relevant, an indication that the amount to be distributed may be more or less than the amount stated in the notice, depending on investment gains or losses and the administrative cost of terminating the plan and distributing benefits;

(iii) A description of the distribution options available under the plan and a request that the participant or beneficiary elect a form of distribution and inform the plan administrator (or other fiduciary) identified in paragraph (e)(1)(vii) of this section of that election;

(iv) A statement explaining that, if a participant or beneficiary fails to make an election within 30 days from receipt of the notice, the plan will distribute the account balance of the participant or beneficiary to an individual retirement plan (i.e., individual retirement account or annuity described in paragraph (d)(1)(i) or (d)(1)(ii) of this section) and the account balance will be invested in an investment product designed to preserve principal and provide a reasonable rate of return and liquidity;

(v) A statement explaining what fees, if any, will be paid from the participant or beneficiary’s individual retirement plan (described in paragraph
(d)(1)(i) or (d)(1)(ii) of this section), if such information is known at the time of the furnishing of this notice:

(vi) The name, address and phone number of the individual retirement plan (described in paragraph (d)(1)(i) or (d)(1)(ii) of this section) provider, if such information is known at the time of the furnishing of this notice; and

(vii) The name, address, and telephone number of the plan administrator (or other fiduciary) from whom a participant or beneficiary may obtain additional information concerning the termination.

(2) Manner of furnishing notice. (i) For purposes of paragraph (e)(1) of this section, a notice shall be furnished to each participant or beneficiary in accordance with the requirements of §2520.104b-1(b)(1) of this chapter to the last known address of the participant or beneficiary; and

(ii) In the case of a notice that is returned to the plan as undeliverable, the plan fiduciary shall, consistent with its duties under section 404(a)(1) of ERISA, take steps to locate the participant or beneficiary and provide notice prior to making the distribution. If, after such steps, the fiduciary is unsuccessful in locating and furnishing notice to a participant or beneficiary, the participant or beneficiary shall be deemed to have been furnished the notice and to have failed to make an election within 30 days for purposes of paragraph (b)(2) of this section.

(f) Model notice. The appendix to this section contains a model notice that may be used to discharge the notification requirements under this section. Use of the model notice is not mandatory. However, use of an appropriately completed model notice will be deemed to satisfy the requirements of paragraph (e)(1) of this section.
§ 2550.404a-3

APPENDIX TO § 2550.404a-3

NOTICE OF PLAN TERMINATION

[Date of notice]

[Name and last known address of plan participant or beneficiary]

Re: [Name of plan]

Dear [Name of plan participant or beneficiary]:

This notice is to inform you that [name of the plan] (the Plan) has been terminated and we are in the process of winding it up.

We have determined that you have an interest in the Plan, either as a plan participant or beneficiary. Your account balance in the Plan on [date] is/ was [account balance]. We will be distributing this money as permitted under the terms of the Plan and federal regulations. [If applicable, insert the following sentence: The actual amount of your distribution may be more or less than the amount stated in this notice depending on investment gains or losses and the administrative cost of terminating your plan and distributing your benefits.]

Your distribution options under the Plan are [add a description of the Plan’s distribution options]. It is very important that you elect one of these forms of distribution and inform us of your election. The process for informing us of this election is [enter a description of the Plan’s election process].

If you do not make an election within 30 days from your receipt of this notice, your account balance will be transferred directly to an individual retirement plan (inherited individual retirement plan in the case of a nonspouse beneficiary). [If the name of the provider of the individual retirement plan is known, include the following sentence: The name of the provider of the individual retirement plan is [name, address and phone number of the individual retirement plan provider].] Pursuant to federal law, your money in the individual retirement plan would then be invested in an investment product designed to preserve principal and provide a reasonable rate of return and liquidity. [If fee information is known, include the following sentence: Should your money be transferred into an individual retirement plan, [name of the financial institution] charges the following fees for its services: [add a statement of fees, if any, that will be paid from the participant or beneficiary’s individual retirement plan].]

For more information about the termination, your account balance, or distribution options, please contact [name, address, and telephone number of the plan administrator or other appropriate contact person].

Sincerely,

[Name of plan administrator or appropriate designee]
§ 2550.404a–4 Selection of annuity providers—safe harbor for individual account plans.

(a) Scope. (1) This section establishes a safe harbor for satisfying the fiduciary duties under section 404(a)(1)(B) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1104–1114, in selecting an annuity provider and contract for benefit distributions from an individual account plan. For guidance concerning the selection of an annuity provider for defined benefit plans see 29 CFR 2509.95–1.

(2) This section sets forth an optional means for satisfying the fiduciary responsibilities under section 404(a)(1)(B) of ERISA with respect to the selection of an annuity provider or contract for benefit distributions. This section does not establish minimum requirements or the exclusive means for satisfying these responsibilities.

(b) Safe harbor. The selection of an annuity provider for benefit distributions from an individual account plan satisfies the requirements of section 404(a)(1)(B) of ERISA if the fiduciary:

(1) Engages in an objective, thorough and analytical search for the purpose of identifying and selecting providers from which to purchase annuities;

(2) Appropriately considers information sufficient to assess the ability of the annuity provider to make all future payments under the annuity contract;

(3) Appropriately considers the cost (including fees and commissions) of the annuity contract in relation to the benefits and administrative services to be provided under such contract;

(4) Appropriately concludes that, at the time of the selection, the annuity provider is financially able to make all future payments under the annuity contract and the cost of the annuity contract is reasonable in relation to the benefits and services to be provided under the contract; and

(5) If necessary, consults with an appropriate expert or experts for purposes of compliance with the provisions of this paragraph (b).

(c) Time of selection. For purposes of paragraph (b) of this section, the “time of selection” may be either:

(1) The time that the annuity provider and contract are selected for distribution of benefits to a specific participant or beneficiary; or

(2) The time that the annuity provider is selected to provide annuity contracts at future dates to participants or beneficiaries, provided that the selecting fiduciary periodically reviews the continuing appropriateness of the conclusion described in paragraph (b)(4) of this section, taking into account the factors described in paragraphs (b)(2), (3) and (5) of this section. For purposes of this paragraph (c)(2), a fiduciary is not required to review the appropriateness of this conclusion with respect to any annuity contract purchased for any specific participant or beneficiary.

§ 2550.404a–5 Fiduciary requirements for disclosure in participant-directed individual account plans.

(a) General. The investment of plan assets is a fiduciary act governed by the fiduciary standards of section 404(a)(1)(A) and (B) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1001 et seq. (all section references herein are references to ERISA unless otherwise indicated). Pursuant to section 404(a)(1)(A) and (B), fiduciaries must discharge their duties with respect to the plan prudently and solely in the interest of participants and beneficiaries. When the documents and instruments governing an individual account plan, described in paragraph (b)(2) of this section, provide for the allocation of investment responsibilities to participants and beneficiaries, the plan administrator, as defined in section 3(16), must take steps to ensure, consistent with section 404(a)(1)(A) and (B), that such participants and beneficiaries, on a regular and periodic basis, are made aware of their rights and responsibilities with respect to the investment of assets held in, or contributed to, their accounts and are provided sufficient information regarding the plan, including fees and expenses, and regarding

619
designated investment alternatives, including fees and expenses attendant thereto, to make informed decisions with regard to the management of their individual accounts.

(b) Satisfaction of duty to disclose. (1) In general. The plan administrator of a covered individual account plan must comply with the disclosure requirements set forth in paragraphs (c) and (d) of this section with respect to each participant or beneficiary that, pursuant to the terms of the plan, has the right to direct the investment of assets held in, or contributed to, his or her individual account. Compliance with paragraphs (c) and (d) of this section will satisfy the duty to make the regular and periodic disclosures described in paragraph (a) of this section, provided that the information contained in such disclosures is complete and accurate. A plan administrator will not be liable for the completeness and accuracy of information used to satisfy these disclosure requirements when the plan administrator reasonably and in good faith relies on information received from or provided by a plan service provider or the issuer of a designated investment alternative.

(2) Covered individual account plan. For purposes of paragraph (b)(1) of this section, a “covered individual account plan” is any participant-directed individual account plan as defined in section 3(34) of ERISA, except that such term shall not include plans involving individual retirement accounts or individual retirement annuities described in sections 408(k) (“simplified employee pension”) or 408(p) (“simple retirement account”) of the Internal Revenue Code of 1986.

(c) Disclosure of plan-related information. A plan administrator (or person designated by the plan administrator to act on its behalf) shall provide to each participant or beneficiary the plan-related information described in paragraphs (c)(1) through (4) of this section, based on the latest information available to the plan.

(1) General. (i) On or before the date on which a participant or beneficiary can first direct his or her investments and at least annually thereafter:

(A) An explanation of the circumstances under which participants and beneficiaries may give investment instructions;

(B) An explanation of any specified limitations on such instructions under the terms of the plan, including any restrictions on transfer to or from a designated investment alternative;

(C) A description of or reference to plan provisions relating to the exercise of voting, tender and similar rights appurtenant to an investment in a designated investment alternative as well as any restrictions on such rights;

(D) An identification of any designated investment alternatives offered under the plan;

(E) An identification of any designated investment managers; and

(F) A description of any “brokerage windows,” “self-directed brokerage accounts,” or similar plan arrangements that enable participants and beneficiaries to select investments beyond those designated by the plan.

(ii) If there is a change to the information described in paragraph (c)(1)(i)(A) through (F) of this section, each participant and beneficiary must be furnished a description of such change at least 30 days, but not more than 90 days, in advance of the effective date of such change, unless the inability to provide such advance notice is due to events that were unforeseeable or circumstances beyond the control of the plan administrator, in which case notice of such change must be furnished as soon as reasonably practicable.

(2) Administrative expenses. (i)(A) On or before the date on which a participant or beneficiary can first direct his or her investments and at least annually thereafter, an explanation of any fees and expenses for general plan administrative services (e.g., legal, accounting, recordkeeping), which may be charged against the individual accounts of participants and beneficiaries and are not reflected in the total annual operating expenses of any designated investment alternative, as well as the basis on which such charges will be allocated (e.g., pro rata, per capita) to, or affect the balance of, each individual account.

(B) If there is a change to the information described in paragraph
(c)(2)(i)(A) of this section, each participant and beneficiary must be furnished a description of such change at least 30 days, but not more than 90 days, in advance of the effective date of such change, unless the inability to provide such advance notice is due to events that were unforeseeable or circumstances beyond the control of the plan administrator, in which case notice of such change must be furnished as soon as reasonably practicable.

(ii) At least quarterly, a statement that includes:

(A) The dollar amount of the fees and expenses described in paragraph (c)(2)(i)(A) of this section that are actually charged (whether by liquidating shares or deducting dollars) during the preceding quarter to the participant’s or beneficiary’s account for such services;

(B) A description of the services to which the charges relate (e.g., plan administration, including recordkeeping, legal, accounting services); and

(C) If applicable, an explanation that, in addition to the fees and expenses disclosed pursuant to paragraph (c)(2)(ii) of this section, some of the plan’s administrative expenses for the preceding quarter were paid from the total annual operating expenses of one or more of the plan’s designated investment alternatives (e.g., through revenue sharing arrangements, Rule 12b–1 fees, sub-transfer agent fees).

(3) Individual expenses. (i)(A) On or before the date on which a participant or beneficiary can first direct his or her investments and at least annually thereafter, an explanation of any fees and expenses that may be charged against the individual account of a participant or beneficiary on an individual, rather than on a plan-wide, basis (e.g., fees attendant to processing plan loans or qualified domestic relations orders, fees for investment advice, fees for brokerage windows, commissions, front- or back-end loads or sales charges, redemption fees, transfer fees and similar expenses, and optional rider charges in annuity contracts) and which are not reflected in the total annual operating expenses of any designated investment alternative.

(B) If there is a change to the information described in paragraph (c)(3)(i)(A) of this section, each participant and beneficiary must be furnished a description of such change at least 30 days, but not more than 90 days, in advance of the effective date of such change, unless the inability to provide such advance notice is due to events that were unforeseeable or circumstances beyond the control of the plan administrator, in which case notice of such change must be furnished as soon as reasonably practicable.

(ii) At least quarterly, a statement that includes:

(A) The dollar amount of the fees and expenses described in paragraph (c)(3)(i)(A) of this section that are actually charged (whether by liquidating shares or deducting dollars) during the preceding quarter to the participant’s or beneficiary’s account for individual services; and

(B) A description of the services to which the charges relate (e.g., loan processing fee).

(4) Disclosures on or before first investment. The requirements of paragraphs (c)(1)(i), (c)(2)(i)(A), (c)(3)(i)(A) of this section to furnish information on or before the date on which a participant or beneficiary can first direct his or her investments may be satisfied by furnishing to the participant or beneficiary the most recent annual disclosure furnished to participants and beneficiaries pursuant to paragraphs (c)(1)(i), (c)(2)(i)(B) and (c)(3)(i)(B) of this section.

(d) Disclosure of investment-related information. The plan administrator (or person designated by the plan administrator to act on its behalf), based on the latest information available to the plan, shall:

(1) Information to be provided automatically. Except as provided in paragraph (i) of this section, furnish to each participant or beneficiary on or before the date on which he or she can first direct his or her investments and at least annually thereafter, the following information with respect to each designated investment alternative offered under the plan:

(i) Identifying information. Such information shall include:
(A) The name of each designated investment alternative; and

(B) The type or category of the investment (e.g., money market fund, balanced fund (stocks and bonds), large-cap stock fund, employer stock fund, employer securities).

(ii) Performance data. (A) For designated investment alternatives with respect to which the return is not fixed, the average annual total return of the investment for 1-, 5-, and 10-calendar year periods (or for the life of the alternative, if shorter) ending on the date of the most recently completed calendar year; as well as a statement indicating that an investment’s past performance is not necessarily an indication of how the investment will perform in the future; and

(B) For designated investment alternatives with respect to which the return is fixed or stated for the term of the investment, both the fixed or stated annual rate of return and the term of the investment. If, with respect to such a designated investment alternative, the issuer reserves the right to adjust the fixed or stated rate of return prospectively during the term of the contract or agreement, the current rate of return, the minimum rate guaranteed under the contract, if any, and a statement advising participants and beneficiaries that the issuer may adjust the rate of return prospectively and how to obtain (e.g., telephone or Web site) the most recent rate of return required under this section.

(iii) Benchmarks. For designated investment alternatives with respect to which the return is not fixed, the name and returns of an appropriate broad-based securities market index over the 1-, 5-, and 10-calendar year periods (or for the life of the alternative, if shorter) comparable to the performance data periods provided under paragraph (d)(1)(ii)(A) of this section, and which is not administered by an affiliate of the investment issuer, its investment adviser, or a principal underwriter, unless the index is widely recognized and used.

(iv) Fee and expense information. (A) For designated investment alternatives with respect to which the return is not fixed:

(1) The amount and a description of each shareholder-type fee (fees charged directly against a participant’s or beneficiary’s investment, such as commissions, sales loads, sales charges, deferred sales charges, redemption fees, surrender charges, exchange fees, account fees, and purchase fees, which are not included in the total annual operating expenses of any designated investment alternative) and a description of any restriction or limitation that may be applicable to a purchase, transfer, or withdrawal of the investment in whole or in part (such as round trip, equity wash, or other restrictions);

(2) The total annual operating expenses of the investment expressed as a percentage (i.e., expense ratio), calculated in accordance with paragraph (h)(5) of this section;

(3) The total annual operating expenses of the investment for a one-year period expressed as a dollar amount for a $1,000 investment (assuming no returns and based on the percentage described in paragraph (d)(1)(iv)(A)(2) of this section);

(4) A statement indicating that fees and expenses are only one of several factors that participants and beneficiaries should consider when making investment decisions; and

(5) A statement that the cumulative effect of fees and expenses can substantially reduce the growth of a participant’s or beneficiary’s retirement account and that participants and beneficiaries can visit the Employee Benefit Security Administration’s Web site for an example demonstrating the long-term effect of fees and expenses.

(B) For designated investment alternatives with respect to which the return is fixed for the term of the investment, the amount and a description of any shareholder-type fees and a description of any restriction or limitation that may be applicable to a purchase, transfer or withdrawal of the investment in whole or in part.

(v) Internet Web site address. An Internet Web site address that is sufficiently specific to provide participants and beneficiaries access to the following information regarding the designated investment alternative:
 Employee Benefits Security Admin., Labor § 2550.404a–5

(A) The name of the alternative’s issuer;

(B) The alternative’s objectives or goals in a manner consistent with Securities and Exchange Commission Form N–1A or N–3, as appropriate;

(C) The alternative’s principal strategies (including a general description of the types of assets held by the investment) and principal risks in a manner consistent with Securities and Exchange Commission Form N–1A or N–3, as appropriate;

(D) The alternative’s portfolio turnover rate in a manner consistent with Securities and Exchange Commission Form N–1A or N–3, as appropriate;

(E) The alternative’s performance data described in paragraph (d)(1)(ii) of this section updated on at least a quarterly basis, or more frequently if required by other applicable law; and

(F) The alternative’s fee and expense information described in paragraph (d)(1)(iv) of this section.

(vi) Glossary. A general glossary of terms to assist participants and beneficiaries in understanding the designated investment alternatives, or an Internet Web site address that is sufficiently specific to provide access to such a glossary along with a general explanation of the purpose of the address.

(vii) Annuity options. If a designated investment alternative is a part of a contract, fund or product that permits participants or beneficiaries to allocate contributions toward the future purchase of a stream of retirement income payments guaranteed by an insurance company, the information set forth in paragraph (i)(2)(i) through (i)(2)(vii) of this section with respect to the annuity option, to the extent such information is not otherwise included in investment-related fees and expenses described in paragraph (d)(1)(iv).

(ii) Nothing in this section shall preclude a plan administrator from including additional information that the plan administrator determines appropriate for such comparisons, provided such information is not inaccurate or misleading.

(3) Information to be provided subsequent to investment. Furnish to each investing participant or beneficiary, subsequent to an investment in a designated investment alternative, any materials provided to the plan relating to the exercise of voting, tender and similar rights appurtenant to the investment, to the extent that such rights are passed through to such participant or beneficiary under the terms of the plan.

(4) Information to be provided upon request. Furnish to each participant or beneficiary pursuant to paragraph (d)(1) of this section.

(2) Comparative format. (i) Furnish the information described in paragraph (d)(1) and, if applicable, paragraph (i) of this section in a chart or similar format that is designed to facilitate a comparison of such information for each designated investment alternative available under the plan and prominently displays the date, and that includes:

(A) A statement indicating the name, address, and telephone number of the plan administrator (or a person or persons designated by the plan administrator to act on its behalf) to contact for the provision of the information required by paragraph (d)(4) of this section;

(B) A statement that additional investment-related information (including more current performance information) is available at the listed Internet Web site addresses (see paragraph (d)(1)(v) of this section); and

(C) A statement explaining how to request and obtain, free of charge, paper copies of the information required to be made available on a Web site pursuant to paragraph (d)(1)(v), paragraph (i)(2)(vi), relating to annuity options, or paragraph (i)(3), relating to fixed-return investments, of this section.

(ii) Nothing in this section shall preclude a plan administrator from including additional information that the plan administrator determines appropriate for such comparisons, provided such information is not inaccurate or misleading.

(3) Information to be provided subsequent to investment. Furnish to each investing participant or beneficiary, subsequent to an investment in a designated investment alternative, any materials provided to the plan relating to the exercise of voting, tender and similar rights appurtenant to the investment, to the extent that such rights are passed through to such participant or beneficiary under the terms of the plan.

(4) Information to be provided upon request. Furnish to each participant or

623
beneficiary, either at the times specified in paragraph (d)(1), or upon request, the following information relating to designated investment alternatives—

(i) Copies of prospectuses (or, alternatively, any short-form or summary prospectus, the form of which has been approved by the Securities and Exchange Commission) for the disclosure of information to investors by entities registered under either the Securities Act of 1933 or the Investment Company Act of 1940, or similar documents relating to designated investment alternatives that are provided by entities that are not registered under either of these Acts;

(ii) Copies of any financial statements or reports, such as statements of additional information and shareholder reports, and of any other similar materials relating to the plan’s designated investment alternatives, to the extent such materials are provided to the plan;

(iii) A statement of the value of a share or unit of each designated investment alternative as well as the date of the valuation; and

(iv) A list of the assets comprising the portfolio of each designated investment alternative which constitute plan assets within the meaning of 29 CFR 2510.3–101 and the value of each such asset (or the proportion of the investment which it comprises).

(e) Form of disclosure. (1) The information required to be disclosed pursuant to paragraphs (c)(1)(i), (c)(2)(i)(A), and (c)(3)(i)(A) of this section may be provided as part of the plan’s summary plan description furnished pursuant to ERISA section 102 or as part of a pension benefit statement furnished pursuant to ERISA section 105(a)(1)(A)(i). If such summary plan description or pension benefit statement is furnished at a frequency that comports with paragraph (c)(1)(i) of this section.

(2) The information required to be disclosed pursuant to paragraphs (c)(2)(ii) and (c)(3)(ii) of this section may be included as part of a pension benefit statement furnished pursuant to ERISA section 105(a)(1)(A)(i).

(3) A plan administrator that uses and accurately completes the model in the Appendix, taking into account each designated investment alternative offered under the plan, will be deemed to have satisfied the requirements of paragraph (d)(2) of this section.

(4) Except as otherwise explicitly required herein, fees and expenses may be expressed in terms of a monetary amount, formula, percentage of assets, or per capita charge.

(5) The information required to be prepared by the plan administrator for disclosure under this section shall be written in a manner calculated to be understood by the average plan participant.

(f) Selection and monitoring. Nothing herein is intended to relieve a fiduciary from its duty to prudently select and monitor providers of services to the plan or designated investment alternatives offered under the plan.

(g) Manner of furnishing. Reserved.

(h) Definitions. For purposes of this section, the term—

(1) At least annually thereafter means at least once in any 14-month period, without regard to whether the plan operates on a calendar or fiscal year basis.

(2) At least quarterly means at least once in any 3-month period, without regard to whether the plan operates on a calendar or fiscal year basis.

(3) Average annual total return means the average annual compounded rate of return that would equate an initial investment in a designated investment alternative to the ending redeemable value of that investment calculated with the before tax methods of computation prescribed in Securities and Exchange Commission Form N–1A, N–3, or N–4, as appropriate, except that such method of computation may exclude any front-end, deferred or other sales loads that are waived for the participants and beneficiaries of the covered individual account plan.

(4) Designated investment alternative means any investment alternative designated by the plan into which participants and beneficiaries may direct the investment of assets held in, or contributed to, their individual accounts. The term “designated investment alternative” shall not include “brokerage windows,” “self-directed brokerage accounts,” or similar plan arrangements that enable participants and
beneficiaries to select investments beyond those designated by the plan.

(5) Total annual operating expenses means:

(i) In the case of a designated investment alternative that is registered under the Investment Company Act of 1940, the annual operating expenses and other asset-based charges before waivers and reimbursements (e.g., investment management fees, distribution fees, service fees, administrative expenses, separate account expenses, mortality and expense risk fees) that reduce the alternative’s rate of return, expressed as a percentage, calculated in accordance with the required Securities and Exchange Commission form, e.g., Form N-1A (open-end management investment companies) or Form N-3 or N-4 (separate accounts offering variable annuity contracts); or

(ii) In the case of a designated investment alternative that is not registered under the Investment Company Act of 1940, the sum of the fees and expenses described in paragraphs (h)(5)(i)(A) through (C) of this section before waivers and reimbursements, for the alternative’s most recently completed fiscal year, expressed as a percentage of the alternative’s average net asset value for that year—

(A) Management fees as described in the Securities and Exchange Commission Form N-1A that reduce the alternative’s rate of return.

(B) Distribution and/or servicing fees as described in the Securities and Exchange Commission Form N-1A that reduce the alternative’s rate of return, and

(C) Any other fees or expenses not included in paragraphs (h)(5)(i)(A) or (B) of this section that reduce the alternative’s rate of return (e.g., externally negotiated fees, custodial expenses, legal expenses, accounting expenses, transfer agent expenses, recordkeeping fees, administrative fees, separate account expenses, mortality and expense risk fees), excluding brokerage costs described in Item 21 of Securities and Exchange Commission Form N-1A.

(1) Special rules. The rules set forth in this paragraph apply solely for purposes of paragraph (d)(1) of this section.

(1) Qualifying employer securities. In the case of designated investment alternatives designed to invest in, or primarily in, qualifying employer securities, within the meaning of section 407 of ERISA, the following rules shall apply—

(i) In lieu of the requirements of paragraph (d)(1)(v)(C) of this section (relating to principal strategies and principal risks), provide an explanation of the importance of a well-balanced and diversified investment portfolio.

(ii) The requirements of paragraph (d)(1)(v)(D) of this section (relating to portfolio turnover rate) do not apply to such designated investment alternatives.

(iii) The requirements of paragraph (d)(1)(v)(F) of this section (relating to fee and expense information) do not apply to such designated investment alternatives, unless the designated investment alternative is a fund with respect to which participants or beneficiaries acquire units of participation, rather than actual shares, in exchange for their investment.

(iv) The requirements of paragraph (d)(1)(iv)(A)(2) of this section (relating to total annual operating expenses expressed as a percentage) do not apply to such designated investment alternatives, unless the designated investment alternative is a fund with respect to which participants or beneficiaries acquire units of participation, rather than actual shares, in exchange for their investment.

(v) The requirements of paragraph (d)(1)(iv)(A)(3) of this section (relating to total annual operating expenses expressed as a dollar amount per $1,000 invested) do not apply to such designated investment alternatives, unless the designated investment alternative is a fund with respect to which participants or beneficiaries acquire units of participation, rather than actual shares, in exchange for their investment.

(vi)(A) With respect to the requirement in paragraph (d)(1)(ii)(A) of this section (relating to performance data for 1-, 5-, and 10-year periods), the definition of “average annual total return” as defined in paragraph (i)(1)(vi)(B) of this section shall apply to such designated investment alternatives in lieu
of the definition in paragraph (b)(3) of this section if the qualifying employer securities are publicly traded on a national exchange or generally recognized market and the designated investment alternative is not a fund with respect to which participants or beneficiaries acquire units of participation, rather than actual shares, in exchange for their investment.

(B) The term “average annual total return” means the change in value of an investment in one share of stock on an annualized basis over a specified period, calculated by taking the sum of the dividends paid during the measurement period, assuming reinvestment, plus the difference between the stock price (consistent with ERISA section 3(18)) at the end and at the beginning of the measurement period; reinvestment of dividends is assumed to be in stock at market prices at approximately the same time actual dividends are paid.

(C) The definition of “average annual total return” in paragraph (i)(1)(vi)(B) of this section shall apply to such designated investment alternatives consisting of employer securities that are not publicly traded on a national exchange or generally recognized market, unless the designated investment alternative is a fund with respect to which participants or beneficiaries acquire units of participation, rather than actual shares, in exchange for their investment. Changes in value shall be calculated using principles similar to those set forth in paragraph (i)(1)(vi)(B) of this section.

(2) Annuity options. In the case of a designated investment alternative that is a contract, fund or product that permits participants or beneficiaries to allocate contributions toward the current purchase of a stream of retirement income payments guaranteed by an insurance company, the plan administrator shall, in lieu of the information required by paragraphs (d)(1)(i) through (d)(1)(v), provide each participant or beneficiary the following information with respect to each such option:

(i) The name of the contract, fund or product;

(ii) The option’s objectives or goals (e.g., to provide a stream of fixed retirement income payments for life);

(iii) The benefits and factors that determine the price (e.g., age, interest rates, form of distribution) of the guaranteed income payments;

(iv) Any limitations on the ability of a participant or beneficiary to withdraw or transfer amounts allocated to the option (e.g., lock-ups) and any fees or charges applicable to such withdrawals or transfers;

(v) Any fees that will reduce the value of amounts allocated by participants or beneficiaries to the option, such as surrender charges, market value adjustments, and administrative fees;

(vi) A statement that guarantees of an insurance company are subject to its long-term financial strength and claims-paying ability; and

(vii) An Internet Web site address that is sufficiently specific to provide participants and beneficiaries access to the following information—

(A) The name of the option’s issuer and of the contract, fund or product;

(B) Description of the option’s objectives or goals;

(C) Description of the option’s distribution alternatives/guaranteed income payments (e.g., payments for life, payments for a specified term, joint and survivor payments, optional rider payments), including any limitations on the right of a participant or beneficiary to receive such payments;

(D) Description of costs and/or factors taken into account in determining the price of benefits under an option’s distribution alternatives/guaranteed income payments (e.g., age, interest rates, other annuitization assumptions);

(E) Description of any limitations on the right of a participant or beneficiary to withdraw or transfer amounts allocated to the option and any fees or charges applicable to a withdrawal or transfer; and

(F) Description of any fees that will reduce the value of amounts allocated by participants or beneficiaries to the option (e.g., surrender charges, market value adjustments, administrative fees).
(3) Fixed-return investments. In the case of a designated investment alternative with respect to which the return is fixed for the term of the investment, the plan administrator shall, in lieu of complying with the requirements of paragraph (d)(1)(v) of this section, provide an Internet Web site address that is sufficiently specific to provide participants and beneficiaries access to the following information—

(i) The name of the alternative’s issuer;

(ii) The alternative’s objectives or goals (e.g., to provide stability of principal and guarantee a minimum rate of return);

(iii) The alternative’s performance data described in paragraph (d)(1)(ii)(B) of this section updated on at least a quarterly basis, or more frequently if required by other applicable law;

(iv) The alternative’s fee and expense information described in paragraph (d)(1)(iv)(B) of this section.

(4) Target date or similar funds. Reserved.

(j) Dates. (1) Effective date. This section shall be effective on December 20, 2010.

(2) Applicability date. This section shall apply to covered individual account plans for plan years beginning on or after November 1, 2011.

(3) Transitional rules.

(i) (A) Notwithstanding paragraphs (b), (c) and (d) of this section, the initial disclosures required on or before the date on which a participant or beneficiary can first direct his or her investments must be furnished no later than the later of 60 days after such applicability date or 60 days after the effective date of 29 CFR 2550.408b-2(c).

(B) Notwithstanding paragraphs (b) and (c) of this section, the initial disclosures required under paragraphs (c)(2)(ii) and (c)(3)(i) of this section must be furnished no later than 45 days after the end of the quarter in which the disclosure referred to in paragraph (j)(3)(i)(A) of this section was required to be furnished to participants and beneficiaries.

(ii) For plan years beginning before October 1, 2021, if a plan administrator reasonably and in good faith determines that it does not have the information on expenses attributable to the plan that is necessary to calculate, in accordance with paragraph (h)(3) of this section, the 5-year and 10-year average annual total returns for a designated investment alternative that is not registered under the Investment Company Act of 1940, the plan administrator may use a reasonable estimate of such expenses or the plan administrator may use the most recently reported total annual operating expenses of the designated investment alternative as a substitute for such expenses. When a plan administrator uses a reasonable estimate or the most recently reported total annual operating expenses as a substitute for actual expenses pursuant to this paragraph, the administrator shall inform participants of the basis on which the returns were determined. Nothing in this section requires disclosure of returns for periods before the inception of a designated investment alternative.
APPENDIX to §2550.404a-5 — Model Comparative Chart

ABC Corporation 401k Retirement Plan
Investment Options – January 1, 20XX

This document includes important information to help you compare the investment options under your retirement plan. If you want additional information about your investment options, you can go to the specific Internet Web site address shown below or you can contact [insert name of plan administrator or designee] at [insert telephone number and address]. A free paper copy of the information available on the Web site[s] can be obtained by contacting [insert name of plan administrator or designee] at [insert telephone number].

Document Summary

This document has 3 parts. Part I consists of performance information for plan investment options. This part shows you how well the investments have performed in the past. Part II shows you the fees and expenses you will pay if you invest in an option. Part III contains information about the annuity options under your retirement plan.

Part I. Performance Information

Table 1 focuses on the performance of investment options that do not have a fixed or stated rate of return. Table 1 shows how these options have performed over time and allows you to compare them with an appropriate benchmark for the same time periods. Past performance does not guarantee how the investment option will perform in the future. Your investment in these options could lose money. Information about an option’s principal risks is available on the Web site[s].

<table>
<thead>
<tr>
<th>Name/Type of Option</th>
<th>Average Annual Total Return as of 12/31/XX</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1yr. 5yr. 10yr. Since Inception</td>
<td>1yr. 5yr. 10yr. Since Inception</td>
</tr>
<tr>
<td>Equity Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Index Fund/ S&amp;P 500 <a href="http://www">www</a>. website address</td>
<td>26.5% .34% -1.03% 9.25%</td>
<td>26.46% .42% -.95% 9.30%</td>
</tr>
<tr>
<td>B Fund/ Large Cap <a href="http://www">www</a>. website address</td>
<td>27.6% .99% N/A 2.26%</td>
<td>27.80% 1.02% N/A 2.77%</td>
</tr>
<tr>
<td>C Fund/ Int’l Stock <a href="http://www">www</a>. website address</td>
<td>36.73% 5.26% 2.29% 9.37%</td>
<td>40.40% 5.40% 2.40% 12.09%</td>
</tr>
<tr>
<td>D Fund/ Mid Cap <a href="http://www">www</a>. website address</td>
<td>40.22% 2.28% 6.13% 3.29%</td>
<td>46.29% 2.40% -.52% 4.16%</td>
</tr>
<tr>
<td>Bond Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Fund/ Bond Index <a href="http://www">www</a>. website address</td>
<td>6.45% 4.43% 6.08% 7.08%</td>
<td>5.93% 4.97% 6.33% 7.01%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Fund/ GICs</td>
<td>.72% 3.36% 3.11% 5.56%</td>
<td>1.8% 3.1% 3.3% 5.75%</td>
</tr>
</tbody>
</table>
Table 2 focuses on the performance of investment options that have a fixed or stated rate of return. Table 2 shows the annual rate of return of each such option, the term or length of time that you will earn this rate of return, and other information relevant to performance.

<table>
<thead>
<tr>
<th>Name/Type of Option</th>
<th>Return</th>
<th>Term</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>H 200X/GIC</td>
<td>4%</td>
<td>2 Yr.</td>
<td>The rate of return does not change during the stated term.</td>
</tr>
<tr>
<td>I LIBOR Plus/ Fixed-Type Investment Account</td>
<td>LIBOR +2%</td>
<td>Quarterly</td>
<td>The rate of return on 12/31/xx was 2.45%. This rate is fixed quarterly, but will never fall below a guaranteed minimum rate of 2%. Current rate of return information is available on the option’s Web site or at 1-800-yyyy-zzzz.</td>
</tr>
<tr>
<td>J Financial Services Co./ Fixed Account Investment</td>
<td>3.75%</td>
<td>6 Mos.</td>
<td>The rate of return on 12/31/xx was 3.75%. This rate of return is fixed for six months. Current rate of return information is available on the option’s Web site or at 1-800-yyyy-zzzz.</td>
</tr>
</tbody>
</table>

Part II. Fee and Expense Information

Table 3 shows fee and expense information for the investment options listed in Table 1 and Table 2. Table 3 shows the Total Annual Operating Expenses of the options in Table 1. Total Annual Operating Expenses are expenses that reduce the rate of return of the investment option. Table 3 also shows Shareholder-type Fees. These fees are in addition to Total Annual Operating Expenses.

<table>
<thead>
<tr>
<th>Name / Type of Option</th>
<th>Total Annual Operating Expenses As a % $1000</th>
<th>Shareholder-Type Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity Funds</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Index Fund/ S&amp;P 500</td>
<td>0.18% $1.80</td>
<td>$20 annual service charge subtracted from investments held in this option if valued at less than $10,000.</td>
</tr>
<tr>
<td>B Fund/ Large Cap</td>
<td>2.45% $24.50</td>
<td>2.25% deferred sales charge subtracted from amounts withdrawn within 12 months of purchase.</td>
</tr>
<tr>
<td>C Fund/ International</td>
<td>0.79% $7.90</td>
<td>5.75% sales charge subtracted from amounts invested.</td>
</tr>
</tbody>
</table>
§ 2550.404a-5  

<table>
<thead>
<tr>
<th>Stock</th>
<th>Bond Funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>D Fund/ Mid Cap ETF</td>
<td>0.20%</td>
<td>$2.00</td>
</tr>
<tr>
<td>E Fund/ Bond Index</td>
<td>0.50%</td>
<td>$5.00</td>
</tr>
<tr>
<td>F Fund/ GICs</td>
<td>0.46%</td>
<td>$4.60</td>
</tr>
<tr>
<td>G Fund/ Stable Value</td>
<td>0.65%</td>
<td>$6.50</td>
</tr>
<tr>
<td>Generations 2020/ Lifecycle Fund</td>
<td>1.50%</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

Fixed Return Investments

| H 200X / GIC | N/A | 12% charge subtracted from amounts withdrawn before maturity. |
| I LIBOR Plus/ Fixed-Type Invest Account | N/A | 5% contingent deferred sales charge subtracted from amounts withdrawn; charge reduced by 1% on 12-month anniversary of each investment. |
| J Financial Serv Co./ Fixed Account Investment | N/A | 90 days of interest subtracted from amounts withdrawn before maturity. |

The cumulative effect of fees and expenses can substantially reduce the growth of your retirement savings. Visit the Department of Labor’s Web site for an example showing the long-term effect of fees and expenses at [http://www.dol.gov/ebsa/publications/401k_employee.html](http://www.dol.gov/ebsa/publications/401k_employee.html). Fees and expenses are only one of many factors to consider when you decide to invest in an option. You may also want to think about whether an investment in a particular option, along with your other investments, will help you achieve your financial goals.

Part III. Annuity Information

Table 4 focuses on the annuity options under the plan. Annuities are insurance contracts that allow you to receive a guaranteed stream of payments at regular intervals, usually beginning when you retire and lasting for your entire life. Annuities are issued by insurance companies. Guarantees of an insurance company are subject to its long-term financial strength and claims-paying ability.

<table>
<thead>
<tr>
<th>Name</th>
<th>Objectives / Goals</th>
<th>Pricing Factors</th>
<th>Restrictions / Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Income Option</td>
<td>To provide a guaranteed stream of income for your life, based on shares you acquire while you work. At age 65, you will receive monthly payments of $10 for each share you own, for your life. For example, if...</td>
<td>The cost of each share depends on your age and interest rates when you buy it. Ordinarily the closer you are to retirement, the more it will cost you to buy a share.</td>
<td>Payment amounts are based on your life expectancy only and would be reduced if you choose a spousal joint and survivor benefit. You will pay a 25%</td>
</tr>
</tbody>
</table>

www. website address
§ 2550.404b–1 Maintenance of the indicia of ownership of plan assets outside the jurisdiction of the district courts of the United States.

(a) No fiduciary may maintain the indicia of ownership of any assets of a plan outside the jurisdiction of the district courts of the United States, unless:

(1) Such assets are:

(1) Securities issued by a person, as defined in section 3(9) of the Employee Retirement Income Security Act of 1974 (Act) (other than an individual), which is not organized under the laws of the United States or a State and


<table>
<thead>
<tr>
<th>Generations 2020 Variable Annuity Option</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www">www</a>. website address</td>
</tr>
</tbody>
</table>

To provide a guaranteed stream of income for your life, or some other period of time, based on your account balance in the Generations 2020 Lifecycle Fund. This option is available through a variable annuity contract that your plan has with ABC Insurance Company.

You have the right to elect fixed annuity payments in the form of a life annuity, a joint and survivor annuity, or a life annuity with a term certain, but the payment amounts will vary based on the benefit you choose. The cost of this right is included in the Total Annual Operating Expenses of the Generations 2020 Lifecycle Fund, listed in Table 3 above.

The cost also includes a guaranteed death benefit payable to a spouse or beneficiary if you die before payments begin. The death benefit is the greater of your account balance or contributions, less any withdrawals.

Maximum surrender charge of 8% of account balance.

Maximum transfer fee of $30 for each transfer over 12 in a year.

Annual service charge of $50 for account balances below $100,000.

Please visit www.ABCPlanglossary.com for a glossary of investment terms relevant to the investment options under this plan. This glossary is intended to help you better understand your options.
§2550.404b–1

29 CFR Ch. XXV (7–1–15 Edition)

does not have its principal place of business within the United States;

(ii) Securities issued by a government other than the government of the United States or of a State, or any political subdivision, agency or instrumentality of such a government;

(iii) Securities issued by a person, as defined in section 3(9) of the Act (other than an individual), the principal trading market for which securities is outside the jurisdiction of the district courts of the United States; or

(iv) Currency issued by a government other than the government of the United States if such currency is maintained outside the jurisdiction of the district courts of the United States solely as an incident to the purchase, sale or maintenance of securities described in paragraph (a)(1) of this section; and

(2)(i) Such assets are under the management and control of a fiduciary which is a corporation or partnership organized under the laws of the United States or a State, which fiduciary has its principal place of business within the United States and which is—

(A) A bank as defined in section 202(a)(2) of the Investment Advisers Act of 1940 that has, as of the last day of its most recent fiscal year, equity capital in excess of $1,000,000;

(B) An insurance company which is qualified under the laws of more than one State to manage, acquire, or dispose of any asset of a plan, which company has, as of the last day of its most recent fiscal year, net worth in excess of $1,000,000 and which is subject to supervision and examination by the State authority having supervision over insurance companies; or

(C) An investment adviser registered under the Investment Advisers Act of 1940 that has, as of the last day of its most recent fiscal year, total client assets under its management and control in excess of $50,000,000 and either

(1) Shareholders’ or partners’ equity in excess of $750,000 or

(2) All of its obligations and liabilities assumed or guaranteed by a person described in paragraph (a)(2)(i)(A), (B), or (C)(i) or (a)(2)(ii)(A)(2) of this section; or

(ii) Such indicia of ownership are either

(A) In the physical possession of, or, as a result of normal business operations, are in transit to the physical possession of, a person which is organized under the laws of the United States or a State, which person has its principal place of business in the United States and which is—

(1) A bank as defined in section 202(a)(2) of the Investment Advisers Act of 1940 that has, as of the last day of its most recent fiscal year, equity capital in excess of $1,000,000;

(2) A broker or dealer registered under the Securities Exchange Act of 1934 that has, as of the last day of its most recent fiscal year, net worth in excess of $750,000; or

(3) A broker or dealer registered under the Securities Exchange Act of 1934 that has all of its obligations and liabilities assumed or guaranteed by a person described in paragraph (a)(2)(ii)(A)(2) of this section, in the custody of an entity designated by the Securities and Exchange Commission as a “satisfactory control location” with respect to such broker or dealer pursuant to Rule 15c3–3 under the Securities Exchange Act of 1934, provided that:

(1) Such entity holds the indicia of ownership as agent for the broker or dealer, and

(2) Such broker or dealer is liable to the plan to the same extent it would be if it retained the physical possession of the indicia of ownership pursuant to paragraph (a)(2)(ii)(A) of this section.

(C) Maintained by a bank described in paragraph (a)(2)(ii)(A)(1), in the custody of an entity that is a foreign securities depository, foreign clearing agency which acts as a securities depository, or foreign bank, which entity is supervised or regulated by a government agency or regulatory authority in the foreign jurisdiction having authority over such depositories, clearing agencies or banks, provided that:

(1) The foreign entity holds the indicia of ownership as agent for the bank; and

(2) The bank is liable to the plan to the same extent it would be if it retained the physical possession of the
Indicia of ownership within the United States;

(3) The indicia of ownership are not subject to any right, charge, security interest, lien or claim of any kind in favor of the foreign entity except for their safe custody or administration;

(4) Beneficial ownership of the assets represented by the indicia of ownership is freely transferable without the payment of money or value other than for safe custody or administration; and

(5) Upon request by the plan fiduciary who is responsible for the selection and retention of the bank, the bank identifies to such fiduciary the name, address and principal place of business of the foreign entity which acts as custodian for the plan pursuant to this paragraph (a)(2)(i)(C), and the name and address of the governmental agency or other regulatory authority that supervises or regulates that foreign entity.

(b) Notwithstanding any requirement of paragraph (a) of this section, a fiduciary with respect to a plan may maintain in Canada the indicia of ownership of plan assets which are attributable to a contribution made on behalf of a plan participant who is a citizen or resident of Canada, if such indicia of ownership must remain in Canada in order for the plan to qualify for and maintain tax exempt status under the laws of Canada or to comply with other applicable laws of Canada or any Province of Canada.

(c) For purposes of this regulation:

(1) The term management and control means the power to direct the acquisition or disposition through purchase, sale, pledging, or other means; and

(2) The term depository means any company, or agency or instrumentality of government, that acts as a custodian of securities in connection with a system for the central handling of securities whereby all securities of a particular class or series of any issuer deposited within the system are treated as fungible and may be transferred, loaned, or pledged by bookkeeping entry without physical delivery of securities certificates.

§2550.404c–1

(2) Opportunity to exercise control. (i) A plan provides a participant or beneficiary an opportunity to exercise control over assets in his account only if:

(A) Under the terms of the plan, the participant or beneficiary has a reasonable opportunity to give investment instructions (in writing or otherwise, with opportunity to obtain written confirmation of such instructions) to an identified plan fiduciary who is obligated to comply with such instructions except as otherwise provided in paragraph (b)(2)(ii)(B) and (d)(2)(ii) of this section; and

(B) The participant or beneficiary is provided or has the opportunity to obtain sufficient information to make informed investment decisions with regard to investment alternatives available under the plan, and incidents of ownership appurtenant to such investments. For purposes of this paragraph, a participant or beneficiary will be considered to have sufficient information if the participant or beneficiary is provided by an identified plan fiduciary (or a person or persons designated by the plan fiduciary to act on his behalf):

(1) An explanation that the plan is intended to constitute a plan described in section 404(c) of the Employee Retirement Income Security Act, and 29 CFR 2550.404c–1, and that the fiduciaries of the plan may be relieved of liability for any losses which are the direct and necessary result of investment instructions given by such participant or beneficiary;

(2) The information required pursuant to 29 CFR 2550.404a–5; and

(3) In the case of plans which offer an investment alternative which is designed to permit a participant or beneficiary to directly or indirectly acquire or sell any employer security (employer security alternative), a description of the procedures established to provide for the confidentiality of information relating to the purchase, holding, and sale of employer securities, and the exercise of voting, tender and similar rights, by participants and beneficiaries, and the name, address and phone number of the plan fiduciary responsible for monitoring compliance with the procedures (see paragraphs (d)(2)(ii)(E)(4)(viii), (viii) and (ix) of this section).

(ii) A plan does not fail to provide an opportunity for a participant or beneficiary to exercise control over his individual account merely because it—

(A) Imposes charges for reasonable expenses. A plan may charge participants’ and beneficiaries’ accounts for the reasonable expenses of carrying out investment instructions, provided that procedures are established under the plan to periodically inform such participants and beneficiaries of actual expenses incurred with respect to their respective individual accounts;

(B) Permits a fiduciary to decline to implement investment instructions by participants and beneficiaries. A fiduciary may decline to implement participant and beneficiary instructions which are described at paragraph (d)(2)(ii) of this section, as well as instructions specified in the plan, including instructions—

(I) Which would result in a prohibited transaction described in ERISA section 406 or section 4975 of the Internal Revenue Code, and

(2) Which would generate income that would be taxable to the plan;

(C) Imposes reasonable restrictions on frequency of investment instructions. A plan may impose reasonable restrictions on the frequency with which participants and beneficiaries may give investment instructions. In no event, however, is such a restriction reasonable unless, with respect to each investment alternative made available by the plan, it permits participants and beneficiaries to give investment instructions with a frequency which is appropriate in light of the market volatility to which the investment alternative may reasonably be expected to be subject, provided that—

(1) At least three of the investment alternatives made available pursuant to the requirements of paragraph (b)(3)(i)(B) of this section, which constitute a broad range of investment alternatives, Permit participants and beneficiaries to give investment instructions no less frequently than once within any three month period; and

(2)(i) At least one of the investment alternatives meeting the requirements
Employee Benefits Security Admin., Labor

§ 2550.404c-1

of paragraph (b)(2)(i)(C)(1) of this section permits participants and beneficiaries to give investment instructions with regard to transfers into the investment alternative as frequently as participants and beneficiaries are permitted to give investment instructions with respect to any investment alternative made available by the plan which permits participants and beneficiaries to give investment instructions more frequently than once within any three month period; or

(ii) With respect to each investment alternative which permits participants and beneficiaries to give investment instructions more frequently than once within any three month period, participants and beneficiaries are permitted to direct their investments from such alternative into an income producing, low risk, liquid fund, subfund, or account as frequently as they are permitted to give investment instructions with respect to each such alternative and, with respect to such fund, subfund or account, participants and beneficiaries are permitted to direct investments from the fund, subfund or account to an investment alternative meeting the requirements of paragraph (b)(2)(i)(C)(1) as frequently as they are permitted to give investment instructions with respect to each such investment alternative.

(iii) Paragraph (c) of this section describes the circumstances under which a participant or beneficiary will be considered to have exercised independent control with respect to a particular transaction.

(3) Broad range of investment alternatives. (i) A plan offers a broad range of investment alternatives only if the available investment alternatives are sufficient to provide the participant or beneficiary with a reasonable opportunity to:

(A) Materiaically affect the potential return on amounts in his individual account with respect to which he is permitted to exercise control and the degree of risk to which such amounts are subject;

(B) Choose from at least three investment alternatives:

(1) Each of which is diversified;

(2) Each of which has materially different risk and return characteristics;

(3) Which in the aggregate enable the participant or beneficiary by choosing among them to achieve a portfolio with aggregate risk and return characteristics at any point within the range normally appropriate for the participant or beneficiary; and

(4) Each of which when combined with investments in the other alternatives tends to minimize through diversification the overall risk of a participant’s or beneficiary’s portfolio;

(C) Diversify the investment of that portion of his individual account with respect to which he is permitted to exercise control so as to minimize the risk of large losses, taking into account the nature of the plan and the size of participants’ or beneficiaries’ accounts. In determining whether a plan provides the participant or beneficiary with a reasonable opportunity
to diversify his investments, the nature of the investment alternatives offered by the plan and the size of the portion of the individual's account over which he is permitted to exercise control must be considered. Where such portion of the account of any participant or beneficiary is so limited in size that the opportunity to invest in look-through investment vehicles is the only prudent means to assure an opportunity to achieve appropriate diversification, a plan may satisfy the requirements of this paragraph only by offering look-through investment vehicles.

(ii) Diversification and look-through investment vehicles. Where look-through investment vehicles are available as investment alternatives to participants and beneficiaries, the underlying investments of the look-through investment vehicles shall be considered in determining whether the plan satisfies the requirements of subparagraphs (b)(3)(i)(B) and (b)(3)(i)(C).

(c) Exercise of control—(1) In general.
   (i) Sections 404(c)(1) and 404(c)(2) of the Act and paragraphs (a) and (d) of this section apply only with respect to a transaction where a participant or beneficiary has exercised independent control in fact with respect to the investment of assets in his individual account under an ERISA section 404(c) plan.

   (ii) For purposes of sections 404(c)(1) and 404(c)(2) of the Act and paragraphs (a) and (d) of this section, a participant or beneficiary will be deemed to have exercised control with respect to voting, tender or similar rights appurtenant to the participant's or beneficiary's ownership interest in an investment alternative, provided that the participant's or beneficiary's investment in the investment alternative was itself the result of an exercise of control; the participant or beneficiary was provided a reasonable opportunity to give instruction with respect to such incidents of ownership, including the provision of the information described in 29 CFR 2550.404a–5(d)(3); and the participant or beneficiary has not failed to exercise control by reason of the circumstances described in paragraph (c)(2) with respect to such incidents of ownership.

   (2) Independent control. Whether a participant or beneficiary has exercised independent control in fact with respect to a transaction depends on the facts and circumstances of the particular case. However, a participant's or beneficiary's exercise of control is not independent in fact if:

   (i) The participant or beneficiary is subjected to improper influence by a plan fiduciary or the plan sponsor with respect to the transaction;

   (ii) A plan fiduciary has concealed material non-public facts regarding the investment from the participant or beneficiary, unless the disclosure of such information by the plan fiduciary to the participant or beneficiary would violate any provision of federal law or any provision of state law which is not preempted by the Act; or

   (iii) The participant or beneficiary is legally incompetent and the responsible plan fiduciary accepts the instructions of the participant or beneficiary knowing him to be legally incompetent.

(3) Transactions involving a fiduciary. In the case of a sale, exchange or leasing of property (other than a transaction described in paragraph (d)(2)(ii)(E) of this section) between an ERISA section 404(c) plan and a plan fiduciary or an affiliate of such a fiduciary, or a loan to a plan fiduciary or an affiliate of such a fiduciary, the participant or beneficiary will not be deemed to have exercised independent control unless the transaction is fair and reasonable to him. For purposes of this paragraph (c)(3), a transaction will be deemed to be fair and reasonable to a participant or beneficiary if he pays no more than, or receives no less than, adequate consideration (as defined in section 3(18) of the Act) in connection with the transaction.

(4) No obligation to advise. A fiduciary has no obligation under part 4 of title I of the Act to provide investment advice to a participant or beneficiary under an ERISA section 404(c) plan.

(d) Effect of independent exercise of control—(1) Participant or beneficiary not a fiduciary. If a participant or beneficiary of an ERISA section 404(c) plan exercises independent control over assets in his individual account in the manner described in paragraph (c),
then such participant or beneficiary is not a fiduciary of the plan by reason of such exercise of control.

(2) Limitation on liability of plan fiduciaries. (i) If a participant or beneficiary of an ERISA section 404(c) plan exercises independent control over assets in his individual account in the manner described in paragraph (c), then no other person who is a fiduciary with respect to such plan shall be liable for any loss, or with respect to any breach of part 4 of title I of the Act, that is the direct and necessary result of that participant’s or beneficiary’s exercise of control.

(ii) Paragraph (d)(2)(i) does not apply with respect to any instruction, which if implemented—

(A) Would not be in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of title I of ERISA;

(B) Would cause a fiduciary to maintain the indicia of ownership of any assets of the plan outside the jurisdiction of the district courts of the United States other than as permitted by section 404(b) of the Act and 29 CFR 2550.404b–1;

(C) Would jeopardize the plan’s tax qualified status under the Internal Revenue Code;

(D) Could result in a loss in excess of a participant’s or beneficiary’s account balance; or

(E) Would result in a direct or indirect:

(I) Sale, exchange, or lease of property between a plan sponsor or any affiliate of the sponsor and the plan except for the acquisition or disposition of any interest in a fund, subfund or portfolio managed by a plan sponsor or an affiliate of the sponsor, or the purchase or sale of any qualifying employer security (as defined in section 407(d)(5) of the Act) which meets the conditions of section 408(e) of ERISA and section (d)(2)(ii)(E)(4)(d) below;

(2) Loan to a plan sponsor or any affiliate of the sponsor;

(3) Acquisition or sale of any employer real property (as defined in section 407(d)(2) of the Act); or

(4) Acquisition or sale of any employer security except to the extent that:

(i) Such securities are qualifying employer securities (as defined in section 407(d)(5) of the Act);

(ii) Such securities are stock or an equity interest in a publicly traded partnership (as defined in section 7704(b) of the Internal Revenue Code of 1986), but only if such partnership is an existing partnership as defined in section 10211(c)(2)(A) of the Revenue Act of 1987 (Public Law 100–203);

(iii) Such securities are publicly traded on a national exchange or other generally recognized market;

(iv) Such securities are traded with sufficient frequency and in sufficient volume to assure that participant and beneficiary directions to buy or sell the security may be acted upon promptly and efficiently;

(v) Information provided to shareholders of such securities is provided to participants and beneficiaries with accounts holding such securities;

(vi) Voting, tender and similar rights with respect to such securities are passed through to participants and beneficiaries with accounts holding such securities;

(vii) Information relating to the purchase, holding, and sale of securities, and the exercise of voting, tender and similar rights with respect to such securities by participants and beneficiaries, is maintained in accordance with procedures which are designed to safeguard the confidentiality of such information, except to the extent necessary to comply with Federal laws or state laws not preempted by the Act;

(viii) The plan designates a fiduciary who is responsible for ensuring that:

The procedures required under subparagraph (d)(2)(ii)(E)(4)(ci) are sufficient to safeguard the confidentiality of the information described in that subparagraph, such procedures are being followed, and the independent fiduciary required by subparagraph (d)(2)(ii)(E)(4)(ix) is appointed; and

(ix) An independent fiduciary is appointed to carry out activities relating to any situations which the fiduciary designated by the plan for purposes of subparagraph (d)(2)(ii)(E)(4)(viii) determines involve a potential for undue employer influence upon participants and beneficiaries with regard to the direct or indirect exercise of shareholder stockholder rights.
§ 2550.404c-1

rights. For purposes of this subpara-
graph, a fiduciary is not independent if
the fiduciary is affiliated with any
sponsor of the plan.

(iii) The individual investment deci-
sions of an investment manager who is
designated directly by a participant or
beneficiary or who manages a look-
through investment vehicle in which a
participant or beneficiary has invested
are not direct and necessary results of
the designation of the investment man-
ger or of investment in the look-
through investment vehicle. However,
this paragraph (d)(2)(iii) shall not be
construed to result in liability under
section 405 of ERISA with respect to a
fiduciary (other than the investment
manager) who would otherwise be re-
lieved of liability by reason of section
404(c)(2) of the Act and paragraph (d) of
this section.

(iv) Paragraph (d)(2)(i) does not serve
to relieve a fiduciary from its duty to
prudently select and monitor any serv-
ice provider or designated investment
alternative offered under the plan.

(3) Prohibited transactions. The relief
provided by section 404(c) of the Act
and this section applies only to the
provisions of part 4 of title I of the Act.
Therefore, nothing in this section re-
lieves a disqualified person from the
taxes imposed by sections 4975 (a) and
(b) of the Internal Revenue Code with
respect to the transactions prohibited
by section 4975(c)(1) of the Code.

(e) Definitions. For purposes of this
section:

(1) Look-through investment vehicle
means:

(i) An investment company described
in section 3(a) of the Investment Com-
pany Act of 1940, or a series investment
company described in section 18(f) of
the 1940 Act or any of the segregated
portfolios of such company;

(ii) A common or collective trust
fund or a pooled investment fund main-
tained by a bank or similar institution,
a deposit in a bank or similar institu-
tion, or a fixed rate investment con-
tract of a bank or similar institution;

(iii) A pooled separate account or a
fixed rate investment contract of an in-
surance company qualified to do busi-
ness in a State; or

(iv) Any entity whose assets include
plan assets by reason of a plan’s invest-
ment in the entity;

(2) Adequate consideration has the
meaning given it in section 3(18) of the
Act and in any regulations under this
title;

(3) An affiliate of a person includes
the following:

(i) Any person directly or indirectly
controlling, controlled by, or under
common control with the person;

(ii) Any officer, director, partner,
employee, an employee of an affiliated
employer, relative (as defined in sec-
ton 3(15) of ERISA), brother, sister, or
spouse of a brother or sister, of the per-
son; and

(iii) Any corporation or partnership
of which the person is an officer direc-
tor or partner.

For purposes of this paragraph (e)(3),
the term “control” means, with re-
spect to a person other than an indi-
vidual, the power to exercise a control-
ing influence over the management or
policies of such person.

(4) A designated investment alternative
is a specific investment identified by a
plan fiduciary as an available invest-
ment alternative under the plan.

(f) Examples. The provisions of this
section are illustrated by the following
examples. Examples (5) through (11) as-
sume that the participant has exer-
cised independent control with respect
to his individual account under an
ERISA section 404(c) plan described in
paragraph (b) and has not directed a
transaction described in paragraph
(d)(2)(i).

(1) Plan A is an individual account plan de-
scribed in section 3(34) of the Act. The plan
states that a plan participant or beneficiary
may direct the plan administrator to invest
any portion of his individual account in a
particular diversified equity fund managed
by an entity which is not affiliated with the
plan sponsor, or any other asset administra-
tively feasible for the plan to hold. However,
the plan provides that the plan adminis-
trator will not implement certain listed in-
structions for which plan fiduciaries would
not be relieved of liability under section
404(c) (see paragraph (d)(2)(i) of this section).
Plan participants and beneficiaries are per-
mitted to give investment instructions dur-
ing the first week of each month with re-
spect to the equity fund and at any time
with respect to other investments. The plan
Employee Benefits Security Admin., Labor § 2550.404c-1

Administrator of Plan A provides each participant and beneficiary with the information described in paragraph (b)(2)(i)(B) of this section, including the information that must be provided on or before the date on which a participant or beneficiary can first direct his or her investments and at least annually thereafter pursuant to 29 CFR 2550.404c-1(b)(2). The plan administrator forwards to the investing participant or beneficiary any materials provided to the plan relating to the exercise of voting, tender, or similar rights attendant to ownership of an interest in such investment (see paragraph (b)(2)(i)(B)(3) of this section and 29 CFR 2550.404a-5(d)(3)). Upon request, the plan administrator provides each participant or beneficiary with copies of any prospectuses (or similar documents relating to designated investment alternatives that are provided by entities that are not registered under the Securities Act of 1933 or the Investment Company Act of 1940), financial statements and reports, and any other materials relating to the designated investment alternatives available under the plan in accordance with 29 CFR 2550.404a-5(d)(4)(i) through (iv). Also upon request, the plan administrator provides each participant and beneficiary with other information required by 29 CFR 2550.404a-5(d)(4) with respect to the equity fund, which is a designated investment alternative, including a statement of the value of a share or unit of the participant’s or beneficiary’s interest in the equity fund and the date of the valuation. Plan A meets the requirements of paragraph (b)(2)(i)(B) of this section regarding the provision of investment alternatives, including a statement of the value of a share or unit of the participant’s or beneficiary’s interest in the equity fund and the date of the valuation. Plan A meets the requirements of paragraph (b)(2)(i)(B) of this section regarding the provision of investment alternatives.

(2) Plan C is an individual account plan described in section 3(34) of the Act under which participants and beneficiaries may choose among three diversified investment alternatives which constitute a broad range of investment alternatives. The plan also permits investment instruction with respect to an employer securities alternative but provides that a participant or beneficiary can invest no more than 25% of his account balance in this alternative. This restriction does not affect the availability of relief under section 404(c) inasmuch as it does not relate to the three diversified investment alternatives and, therefore, does not cause the plan to fail to provide an opportunity to choose from a broad range of investment alternatives.

(5) A participant, P, independently exercises control over assets in his individual account plan by directing a plan fiduciary, F, to invest 100% of his account balance in a single stock. P is not a fiduciary with respect to the plan by reason of his exercise of control and F because he is not liable for any breach of part 4 of title I that is the direct and necessary consequence of P’s exercise of control. However, a prohibited transaction under section 4975(c) of the Internal Revenue Code may have occurred, and, in the absence of an exemption, tax liability may be imposed pursuant to sections 495 (a) and (b) of the Code.

(6) Assume the same facts as in paragraph (f)(5), except that P directs F to purchase the stock from B, who is a party in interest with respect to the plan. Neither P nor F has engaged in a transaction prohibited under section 406 of the Act: P because he is not a fiduciary with respect to the plan by reason of his exercise of control and F because he is not liable for any breach of part 4 of title I that is the direct and necessary consequence of P’s exercise of control. However, a prohibited transaction under section 4975(c) of the Internal Revenue Code may have occurred, and, in the absence of an exemption, tax liability may be imposed pursuant to sections 495 (a) and (b) of the Code.

(7) Assume the same facts as in paragraph (f)(5), except that P does not specify that the stock be purchased from B, and F chooses to purchase the stock from B. In the absence of an exemption, F has engaged in a prohibited transaction described in 406(a) of ERISA because the decision to purchase the stock from B is not a direct or necessary result of P’s exercise of control.

(8) Pursuant to the terms of the plan, plan fiduciary F designates three reputable investment managers whom participants may appoint to manage assets in their individual accounts. Participant P selects M, one of the designated managers, to manage the assets in his account. M prudently manages P’s account for 6 months after which he incurs losses in managing the account through his imprudence. M has engaged in a breach of fiduciary duty because M’s imprudent management of P’s account is not a direct or
necessary result of P’s exercise of control (the choice of M as manager). F has no fiduciary liability for M’s imprudence because he has no affirmative duty to advise P (see paragraph (c)(4)) and because F is relieved of co-fiduciary liability by reason of section 404(c)(2) (see paragraph (d)(2)(iii)). F does have a duty to monitor M’s performance to determine the suitability of continuing M as an investment manager, however, and M’s imprudence would be a factor which F must consider in periodically reevaluating its decision to designate M.

(9) Participant P instructs plan fiduciary F to appoint G as his investment manager pursuant to the terms of the plan which provide P total discretion in choosing an investment manager. Through G’s imprudence, G incurs losses in managing P’s account. G has engaged in a breach of fiduciary duty because G’s imprudent management of P’s account is not a direct or necessary result of P’s exercise of control (the choice of G as manager). Plan fiduciary F has no fiduciary liability for G’s imprudence because F has no obligation to advise P (see paragraph (c)(4)) and because F is relieved of co-fiduciary liability for G’s actions by reason of section 404(c)(2) (see paragraph (d)(2)(iii)). In addition, F also has no duty to determine the suitability of G as an investment manager because the plan does not designate G as an investment manager.

(10) Participant P directs a plan fiduciary, F, a bank, to invest all of the assets in his individual account in a collective trust fund managed by F that is designed to be invested solely in a diversified portfolio of common stocks. Due to economic conditions, the value of the common stocks in the bank collective trust fund declines while the value of publicly-offered fixed income obligations remains relatively stable. F is not liable for any losses incurred by P solely because his individual account was not diversified to include fixed income obligations. Such losses are the direct result of P’s exercise of control; moreover, under paragraph (c)(4) of this section F has no obligation to advise P regarding his investment decisions.

(11) Assume the same facts as in paragraph (f)(10) except that F, in managing the collective trust fund, invests the assets of the fund solely in a few highly speculative stocks. F is liable for losses resulting from its imprudent investment in the speculative stocks and for its failure to diversify the assets of the account. This conduct involves a separate breach of F’s fiduciary duty that is not a direct or necessary result of F’s exercise of control (see paragraph (d)(2)(iii)).

(g) Effective date—(1) In general. Except as provided in paragraph (g)(2), this section is effective with respect to transactions occurring on or after the first day of the second plan year beginning on or after October 13, 1992.

(2) This section is effective with respect to transactions occurring under a plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before October 13, 1992 after the later of the date determined under paragraph (g)(1) or the date on which the last collective bargaining agreement terminates. For purposes of this paragraph (g)(2), any extension or renegotiation of a collective bargaining agreement which is ratified on or after October 13, 1992 is to be disregarded in determining the date on which the agreement terminates.

(3) Transactions occurring before the date determined under subparagraph (g)(1) or (2) of this section, as applicable, are governed by section 404(c) of the Act without regard to the regulation.

under 29 CFR 2550.404c–1 in order for a plan fiduciary to obtain the relief under this section.

(2) The standards set forth in this section apply solely for purposes of determining whether a fiduciary meets the requirements of this regulation. Such standards are not intended to be the exclusive means by which a fiduciary might satisfy his or her responsibilities under the Act with respect to the investment of assets in the individual account of a participant or beneficiary.

(b) Fiduciary relief. (1) Except as provided in paragraphs (b)(2), (3), and (4) of this section, a fiduciary of an individual account plan that permits participants or beneficiaries to direct the investment of assets in their accounts and that meets the conditions of paragraph (c) of this section shall not be liable for any loss, or by reason of any breach under part 4 of title I of ERISA, that is the direct and necessary result of (i) investing all or part of a participant’s or beneficiary’s account in any qualified default investment alternative within the meaning of paragraph (e) of this section; or (ii) investment decisions made by the entity described in paragraph (e)(3) of this section in connection with the management of a qualified default investment alternative.

(2) Nothing in this section shall relieve a fiduciary from his or her duties under part 4 of title I of ERISA to prudently select and monitor any qualified default investment alternative under the plan or from any liability that results from a failure to satisfy these duties, including liability for any resulting losses.

(3) Nothing in this section shall relieve any fiduciary described in paragraph (e)(3)(i) of this section from its fiduciary duties under part 4 of title I of ERISA or from any liability that results from a failure to satisfy these duties, including liability for any resulting losses.

(4) Nothing in this section shall provide relief from the prohibited transaction provisions of section 406 of ERISA, or from any liability that results from a violation of those provisions, including liability for any resulting losses.

(c) Conditions. With respect to the investment of assets in the individual account of a participant or beneficiary, a fiduciary shall qualify for the relief described in paragraph (b)(1) of this section if:

(1) Assets are invested in a qualified default investment alternative within the meaning of paragraph (e) of this section;

(2) The participant or beneficiary on whose behalf the investment is made had the opportunity to direct the investment of the assets in his or her account but did not direct the investment of the assets;

(3) The participant or beneficiary on whose behalf an investment in a qualified default investment alternative may be made is furnished a notice that meets the requirements of paragraph (d) of this section:

(i) (A) At least 30 days in advance of the date of plan eligibility, or at least 30 days in advance of the date of any first investment in a qualified default investment alternative on behalf of a participant or beneficiary described in paragraph (c)(2) of this section; or

(B) On or before the date of plan eligibility provided the participant has the opportunity to make a permissible withdrawal (as determined under section 414(w) of the Internal Revenue Code of 1986, as amended (Code)); and

(ii) Within a reasonable period of time of at least 30 days in advance of each subsequent plan year;

(4) A fiduciary provides to a participant or beneficiary the material set forth in 29 CFR 2550.404c-1(b)(2)(i)(B)(1)(viii) and (ix) and 29 CFR 404c-1(b)(2)(i)(B)(2) relating to a participant’s or beneficiary’s investment in a qualified default investment alternative;

(5)(i) Any participant or beneficiary on whose behalf assets are invested in a qualified default investment alternative may transfer, in whole or in part, such assets to any other investment alternative available under the plan with a frequency consistent with that afforded to a participant or beneficiary who elected to invest in the qualified default investment alternative, but not less frequently than once within any three month period;
§ 2550.404c–5

(ii)(A) Except as provided in paragraph (c)(5)(ii)(B) of this section, any transfer described in paragraph (c)(5)(i), or any permissible withdrawal as determined under section 414(w)(2) of the Code, by a participant or beneficiary of assets invested in a qualified default investment alternative, in whole or in part, resulting from the participant’s or beneficiary’s election to make such a transfer or withdrawal during the 90-day period beginning on the date of the participant’s first elective contribution as determined under section 414(w)(2)(B) of the Code, or other first investment in a qualified default investment alternative on behalf of a participant or beneficiary described in paragraph (c)(2) of this section, shall not be subject to any restrictions, fees or expenses (including surrender charges, liquidation or exchange fees, redemption fees and similar expenses charged in connection with the liquidation of, or transfer from, the investment);

(B) Paragraph (c)(5)(ii)(A) of this section shall not apply to fees and expenses that are charged on an ongoing basis for the operation of the investment itself (such as investment management fees, distribution and/or service fees, “12b–1” fees, or legal, accounting, transfer agent and similar administrative expenses), and are not imposed, or do not vary, based on a participant’s or beneficiary’s decision to withdraw, sell or transfer assets out of the qualified default investment alternative; and

(iii) Following the end of the 90-day period described in paragraph (c)(5)(ii)(A) of this section, any transfer or permissible withdrawal described in this paragraph (c)(5) of this section shall not be subject to any restrictions, fees or expenses not otherwise applicable to a participant or beneficiary who elected to invest in that qualified default investment alternative; and

(6) The plan offers a “broad range of investment alternatives” as determined under section 414(w)(2) of the Code, by a participant or beneficiary of assets invested in a qualified default investment alternative, in whole or in part, resulting from the participant’s or beneficiary’s election to make such a transfer or withdrawal during the 90-day period beginning on the date of the participant’s first elective contribution as determined under section 414(w)(2)(B) of the Code, or other first investment in a qualified default investment alternative on behalf of a participant or beneficiary described in paragraph (c)(2) of this section, shall not be subject to any restrictions, fees or expenses (including surrender charges, liquidation or exchange fees, redemption fees and similar expenses charged in connection with the liquidation of, or transfer from, the investment);

(1) A description of the circumstances under which assets in the individual account of a participant or beneficiary may be invested on behalf of the participant or beneficiary in a qualified default investment alternative; and, if applicable, an explanation of the circumstances under which elective contributions will be made on behalf of a participant, the percentage of such contributions, and the right of the participant to elect not to have such contributions made on the participant’s behalf (or to elect to have such contributions made at a different percentage);

(2) An explanation of the right of participants and beneficiaries to direct the investment of assets in their individual accounts;

(3) A description of the qualified default investment alternative, including a description of the investment objectives, risk and return characteristics (if applicable), and fees and expenses attendant to the investment alternative;

(4) A description of the right of the participants and beneficiaries on whose behalf assets are invested in a qualified default investment alternative to direct the investment of those assets to any other investment alternative under the plan, including a description of any applicable restrictions, fees or expenses in connection with such transfer; and

(5) An explanation of where the participants and beneficiaries can obtain investment information concerning the other investment alternatives available under the plan.

(e) Qualified default investment alternative. For purposes of this section, a qualified default investment alternative means an investment alternative available to participants and beneficiaries that:

(1)(i) Does not hold or permit the acquisition of employer securities, except as provided in paragraph (i).

(ii) Paragraph (e)(1)(i) of this section shall not apply to: (A) Employer securities held or acquired by an investment company registered under the Investment Company Act of 1940 or a similar pooled investment vehicle regulated and subject to periodic examination by a State or Federal agency and

(d) Notice. The notice required by paragraph (c)(3) of this section shall be written in a manner calculated to be understood by the average plan participant and shall contain the following:
with respect to which investment in such securities is made in accordance with the stated investment objectives of the investment vehicle and independent of the plan sponsor or an affiliate thereof; or (B) with respect to a qualified default investment alternative described in paragraph (e)(4)(iii) of this section, employer securities acquired as a matching contribution from the employer/plan sponsor, or employer securities acquired prior to management by the investment management service to the extent the investment management service has discretionary authority over the disposition of such employer securities;

(2) Satisfies the requirements of paragraph (c)(5) of this section regarding the ability of a participant or beneficiary to transfer, in whole or in part, his or her investment from the qualified default investment alternative to any other investment alternative available under the plan;

(3) Is:

(i) Managed by: (A) an investment manager, within the meaning of section 3(38) of the Act; (B) a trustee of the plan that meets the requirements of section 3(38)(A), (B) and (C) of the Act; or

(C) the plan sponsor, or a committee comprised primarily of employees of the plan sponsor, which is a named fiduciary within the meaning of section 402(a)(2) of the Act;

(ii) An investment company registered under the Investment Company Act of 1940; or

(iii) An investment product or fund described in paragraph (e)(4)(iv) or (v) of this section; and

(4) Constitutes one of the following:

(i) An investment fund product or model portfolio that applies generally accepted investment theories, is diversified so as to minimize the risk of large losses and that is designed to provide long-term appreciation and capital preservation through a mix of equity and fixed income exposures consistent with a target level of risk appropriate for participants of the plan as a whole. For purposes of this paragraph (e)(4)(ii), asset allocation decisions for such products and portfolios are not required to take into account risk tolerances, investments or other preferences of an individual participant. An example of such a fund or portfolio may be a “balanced” fund.

(ii) An investment fund product or model portfolio that applies generally accepted investment theories, is diversified so as to minimize the risk of large losses and that is designed to provide varying degrees of long-term appreciation and capital preservation through a mix of equity and fixed income exposures based on the participant’s age, target retirement date (such as normal retirement age under the plan) or life expectancy. Such portfolios are diversified so as to minimize the risk of large losses and change their asset allocations and associated risk levels over time with the objective of becoming more conservative (i.e., decreasing risk of losses) with increasing age. For purposes of this paragraph (e)(4)(i), asset allocation decisions are not required to take into account risk tolerances, investments or other preferences of an individual participant. An example of such a fund or portfolio may be a “life-cycle” or “targeted-retirement-date” fund or account.

(iii) An investment management service with respect to which a fiduciary, within the meaning of paragraph (e)(3)(i) of this section, applying generally accepted investment theories, allocates the assets of a participant’s individual account to achieve varying degrees of long-term appreciation and capital preservation through a mix of equity and fixed income exposures, offered through investment alternatives available under the plan, based on the participant’s age, target retirement date (such as normal retirement age under the plan) or life expectancy. Such portfolios are diversified so as to minimize the risk of large losses and change their asset allocations and associated risk levels for an individual account over time with the objective of becoming more conservative (i.e., decreasing risk of losses) with increasing age. For purposes of this paragraph (e)(4)(iii), asset allocation decisions are not required to take into account risk tolerances, investments or other preferences of an individual participant. An example of such a service may be a “managed account.”
(iv)(A) Subject to paragraph (e)(4)(iv)(B) of this section, an investment product or fund designed to preserve principal and provide a reasonable rate of return, whether or not such return is guaranteed, consistent with liquidity. Such investment product shall for purposes of this paragraph (e)(4)(iv):

1. Seek to maintain, over the term of the investment, the dollar value that is equal to the amount invested in the product; and
2. Be offered by a State or federally regulated financial institution.

(B) An investment product described in this paragraph (e)(4)(iv) shall constitute a qualified default investment alternative for purposes of paragraph (e) of this section for not more than 120 days after the date of the participant’s first elective contribution (as determined under section 414(w)(2)(B) of the Code).

(v)(A) Subject to paragraph (e)(4)(v)(B) of this section, an investment product or fund designed to preserve principal; provide a rate of return generally consistent with that earned on intermediate investment grade bonds; and provide liquidity for withdrawals by participants and beneficiaries, including transfers to other investment alternatives. Such investment product or fund shall, for purposes of this paragraph (e)(4)(v), meet the following requirements:

1. There are no fees or surrender charges imposed in connection with withdrawals initiated by a participant or beneficiary; and
2. Such investment product or fund invests primarily in investment products that are backed by State or federally regulated financial institutions.

(B) An investment product or fund described in this paragraph (e)(4)(v) shall constitute a qualified default investment alternative for purposes of paragraph (e) of this section solely for purposes of assets invested in such product or fund before December 21, 2007.

(vi) An investment fund product or model portfolio that otherwise meets the requirements of this section shall not fail to constitute a product or portfolio for purposes of paragraph (e)(4)(i) or (ii) of this section solely because the product or portfolio is offered through variable annuity or similar contracts or through common or collective trust funds or pooled investment funds and without regard to whether such contracts or funds provide annuity purchase rights, investment guarantees, death benefit guarantees or other features ancillary to the investment fund product or model portfolio.

(f) Preemption of State laws.

(1) Section 514(e)(1) of the Act provides that title I of the Act supersedes any State law that would directly or indirectly prohibit or restrict the inclusion in any plan of an automatic contribution arrangement. For purposes of section 514(e) of the Act and this paragraph (f), an automatic contribution arrangement is an arrangement (or the provisions of a plan) under which:

i. A participant may elect to have the plan sponsor make payments as contributions under the plan on his or her behalf or receive such payments directly in cash;

ii. A participant is treated as having elected to have the plan sponsor make such contributions in an amount equal to a uniform percentage of compensation provided under the plan until the participant specifically elects not to have such contributions made (or specifically elects to have such contributions made at a different percentage); and

iii. Contributions are invested in accordance with paragraphs (a) through (e) of this section.

(2) A State law that would directly or indirectly prohibit or restrict the inclusion in any pension plan of an automatic contribution arrangement is superseded as to any pension plan, regardless of whether such plan includes an automatic contribution arrangement as defined in paragraph (f)(1) of this section.

(3) The administrator of an automatic contribution arrangement within the meaning of paragraph (f)(1) of this section shall be required to have satisfied the notice requirements of section 514(e)(3) of the Act if notices are furnished in accordance with paragraphs (c)(3) and (d) of this section.

(4) Nothing in this paragraph (f) precludes a pension plan from including an automatic contribution arrangement.
§ 2550.407a–1 General rule for the acquisition and holding of employer securities and employer real property.

(a) In general. Section 407(a)(1) of the Employee Retirement Income Security Act of 1974 (the Act) states that except as otherwise provided in section 407 and section 414 of the Act, a plan may not acquire or hold any employer security which is not a qualifying employer security or any employer real property which is not qualifying employer real property. Section 406(a)(1)(E) prohibits a fiduciary from knowingly causing a plan to engage in a transaction which constitutes a direct or indirect acquisition, on behalf of a plan, of any employer security or employer real property in violation of section 407(a), and section 406(a)(2) prohibits a fiduciary who has authority or discretion to control or manage assets of a plan to permit the plan to hold any employer security or employer real property if he knows or should know that holding such security or real property violates section 407(a).

(b) Requirements applicable to all plans. A plan may hold or acquire only employer securities which are qualifying employer securities and employer real property which is qualifying employer real property. A plan may not hold employer securities and employer real property which are not qualifying employer securities and qualifying employer real property, except to the extent that:

(1) The employer security is held by a plan which has made an election under section 407(c)(3) of the Act; or

(2) The employer security is a loan or other extension of credit which satisfies the requirements of section 414(c)(1) of the Act or the employer real property is leased to the employer pursuant to a lease which satisfies the requirements of section 414(c)(2) of the Act.

§ 2550.407a–2 Limitation with respect to the acquisition of qualifying employer securities and qualifying employer real property.

(a) In general. Section 407(a)(2) of the Employee Retirement Income Security Act of 1974 (the Act) provides that a plan may not acquire any qualifying employer security or qualifying employer real property, if immediately after such acquisition the aggregate fair market value of qualifying employer securities and qualifying employer real property held by the plan exceeds 10 percent of the fair market value of the assets of the plan.

(b) Acquisition. For purposes of section 407(a) of the Act, an acquisition by a plan of qualifying employer securities or qualifying employer real property shall include, but not be limited to, an acquisition by purchase, by the exchange of plan assets, by the exercise of warrants or rights, by the conversion of a security (except any acquisition pursuant to a conversion exempt under section 408(b)(7) of the Act), by default of a loan where the qualifying employer security or qualifying employer real property was security for the loan, or by the contribution of such securities or real property to the plan. However, an acquisition of a security shall not be deemed to have occurred if a plan acquires the security as a result of a stock dividend or stock split.

(c) Fair market value—Indebtedness incurred in connection with the acquisition of a plan asset. In determining whether a plan is in compliance with the limitation on the acquisition of qualifying employer securities and qualifying employer real property in section 407(a)(2), the limitation on the holding of qualifying employer securities and qualifying employer real property in section 407(a)(3) and § 2550.407a–3 thereunder, and the requirement regarding the disposition of employer securities and employer real property in section 407(a)(4) and § 2550.407a–4 thereunder, the fair market value of total plan assets shall be the fair market value of such assets less the unpaid amount of:

(1) Any indebtedness incurred by the plan in acquiring such assets;

(2) Any indebtedness incurred before the acquisition of such assets if such
§ 2550.407d–5

Indebtedness would not have been incurred but for such acquisition; and

(3) Any indebtedness incurred after the acquisition of such assets if such indebtedness would not have been incurred but for such acquisition and the incurrence of such indebtedness was reasonably foreseeable at the time of such acquisition. However, the fair market value of qualifying employer securities and qualifying employer real property shall be the fair market value of such assets without any reduction for the unpaid amount of any indebtedness incurred by the plan in connection with the acquisition of such employer securities and employer real property.

(d) Examples. (1) Plan assets have a fair market value of $100,000. The plan has no liabilities other than liabilities for vested benefits of participants and does not own any employer securities or employer real property. The plan proposes to acquire qualifying employer securities with a fair market value of $10,000 by paying $1,000 in cash and borrowing $9,000. The fair market value of plan assets would be $100,000 ($100,000 of plan assets less $1,000 cash payment plus $10,000 of employer securities less $9,000 indebtedness), the fair market value of the qualifying employer securities would be $10,000, which is 10 percent of the fair market value of plan assets. Accordingly, the acquisition would not contravene section 407(a).

(2) Plan assets have a fair market value of $100,000. The plan has liabilities of $20,000 which were incurred in connection with the acquisition of those assets, and does not own any employer securities or employer real property. The plan proposes to pay cash for qualifying employer securities with a fair market value of $10,000. The fair market value of plan assets would be $80,000 ($100,000 of plan assets less $10,000 cash payment plus $10,000 of employer securities less $20,000 indebtedness), the fair market value of the qualifying employer securities would be $10,000, which is 12.5 percent of the fair market value of plan assets. Accordingly, the acquisition would contravene section 407(a).

[42 FR 47201, Sept. 20, 1977]
(3) Immediately following acquisition of the obligation, not more than 25 percent of the assets of the plan is invested in obligations of the employer or an affiliate of the employer.

[42 FR 44388, Sept. 2, 1977]

§ 2550.407d–6 Definition of the term "employee stock ownership plan".

(a) In general.—(1) Type of plan. To be an “ESOP” (employee stock ownership plan), a plan described in section 407(d)(6)(A) of the Employee Retirement Income Security Act of 1974 (the Act), must meet the requirements of this section. See section 407(d)(6)(B).

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

(3) Retroactive amendment. A plan meets the requirements of this section as of the date that it is designated as an ESOP if it is amended retroactively to meet, and in fact does meet, such requirements at any of the following times:

(i) 12 months after the date on which the plan is designated as an ESOP;

(ii) 90 days after a determination letter is issued with respect to the qualification of the plan as an ESOP under this section, but only if the determination is requested by the date in paragraph (a)(3)(i) of this section; or

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

(4) Addition to other plan. An ESOP may form a portion of a plan the balance of which includes a qualified pension, profit-sharing, or stock bonus plan which is not an ESOP. A reference to an ESOP includes an ESOP that forms a portion of another plan.

(5) Conversion of existing plan to an ESOP. If an existing pension, profit-sharing, or stock bonus plan is converted into an ESOP, the requirements of section 404 of the Act, relating to fiduciary duties, and section 401(a) of the Internal Revenue Code (the Code), relating to requirements for plans established for the exclusive benefit of employees, apply to such conversion. A conversion may constitute a termination of an existing plan. For definition of a termination, see the regulations under section 411(d)(3) of the Code and section 401(f) of the Act.

(6) Certain arrangements barred—(1) Buy-sell agreements. An arrangement involving an ESOP that creates a put option must not provide for the issuance of put options other than as provided under §2550.408b–3 (j), (k) and (l). Also, an ESOP must not otherwise obligate itself to acquire securities from a particular security holder at an indefinite time determined upon the happening of an event such as the death of the holder.

(b) Plan designed to invest primarily in qualifying employer securities. A plan constitutes an ESOP only if the plan specifically states that it is designed to invest primarily in qualifying employer securities. Thus, a stock bonus plan or a money purchase pension plan constituting an ESOP may invest part of its assets in other than qualifying employer securities. Such plan will be treated the same as other stock bonus plans or money purchase pension plans qualified under section 401(a) of the Code with respect to those investments.

(c) Regulations of the Secretary of the Treasury. A plan constitutes an ESOP for a plan year only if it meets such other requirements as the Secretary of the Treasury may prescribe by regulation under section 4975(e)(7) of the Code. (See 26 CFR 54.4975–11).

[42 FR 44388, Sept. 2, 1977]

§ 2550.408b–1 General statutory exemption for loans to plan participants and beneficiaries who are parties in interest with respect to the plan.

(a)(1) In general. Section 408(b)(1) of the Employee Retirement Income Security Act of 1974 (the Act or ERISA) exempts from the prohibitions of section 406(a), 406(b)(1) and 406(b)(2) loans by a plan to parties in interest who are participants or beneficiaries of the plan, provided that such loans:

(i) Are available to all such participants and beneficiaries on a reasonably equivalent basis;

(ii) Are not made available to highly compensated employees, officers or shareholders in an amount greater than the amount made available to other employees;
(iii) Are made in accordance with specific provisions regarding such loans set forth in the plan;
(iv) Bear a reasonable rate of interest; and
(v) Are adequately secured.

The Internal Revenue Code (the Code) contains parallel provisions to section 408(b)(1) of the Act. Effective, December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978) transferred the authority of the Secretary of the Treasury to promulgate regulations of the type published herein to the Secretary of Labor. Therefore, all references herein to section 408(b)(1) of the Act should be read to include reference to the parallel provisions of section 4975(d)(1) of the Code.

Section 1114(b)(15)(B) of the Tax Reform Act of 1986 amended section 408(b)(1)(B) of ERISA by deleting the phrase "highly compensated employees, officers or shareholders" and substituting the phrase "highly compensated employees (within the meaning of section 414(q) of the Internal Revenue Code of 1986)." Thus, for plans with participant loan programs which are subject to the amended section 408(b)(1)(B), the requirements of this regulation should be read to conform with the amendment.

(2) Scope. Section 408(b)(1) of the Act does not contain an exemption from acts described in section 406(b)(3) of the Act (prohibiting fiduciaries from receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving plan assets). If a loan from a plan to a participant who is a party in interest with respect to that plan involves an act described in section 406(b)(3), such an act constitutes an act which should be read to conform with the amendment.

(ii) For the purpose of this regulation, the term "loan" will include any renewal or modification of an existing loan agreement, provided that, at the time of each such renewal or modification, the requirements of section 408(b)(1) and this regulation are met.

(4) Examples. The following examples illustrate the provisions of §2550.408b–1(a).

Example 1: T, a trustee of plan P, has exclusive discretion over the management and disposition of plan assets. As a result, T is a fiduciary with respect to P under section 3(21)(A) of the Act and a party in interest with respect to P pursuant to section 3(14)(A) of the Act. Among T's duties as fiduciary is the administration of a participant loan program which meets the requirements of section 408(b)(1) of the Act. Pursuant to strict objective criteria stated under the program, T, who participates in all loan decisions, receives a loan on the same terms as other participants. Although the exercise of T's discretion on behalf of himself may constitute an act of self-dealing described in section 406(b)(1), section 408(b)(1) provides an exemption from section 406(b)(1). As a result, the loan from P to T would be exempt under section 408(b)(1), provided the conditions of that section are otherwise satisfied.
Example 2: P is a plan covering all the employees of E, the employer who established and maintained P. P is a fiduciary with respect to P and an officer of E. The plan documents empower E to establish a participant loan program in accordance with section 408(b)(1) of the Act. Pursuant to an arrangement with E, F establishes a program that limits the use of loan funds to investments in a limited partnership which is established and maintained by E as general partner. Under these facts, the loan program and any loans made pursuant to this program are outside the scope of relief provided by section 408(b)(1) because the loan program is designed to operate for the benefit of E. Under the circumstances described, the diversion of plan assets for E’s benefit would also violate sections 403(c)(1) and 404(a) of the Act.

Example 3: Assume the same facts as in Example 2, above, except that F does not limit the use of loan funds. However, E pressures his employees to borrow funds under P’s participant loan program and then reloan the loan proceeds to E. F, unaware of E’s activities, arranges and approves the loans. If the loans meet all the conditions of section 408(b)(1), such loans will be exempt under that section. However, E’s activities would cause the entire transaction to be viewed as an indirect transfer of plan assets between F and E, who is a party in interest with respect to P, but not the participant borrowing from P. By coercing the employees to engage in loan transactions for its benefit, E has engaged in separate transactions that are not exempt under section 408(b)(1). Accordingly, E would be liable for the payment of excise taxes under section 4975 of the Code.

Example 4: Assume the same facts as in Example 2, above, except that, in return for structuring and administering the loan program as indicated, E agrees to pay F an amount equal to 10 percent of the funds loaned under the program. Such a payment would result in a separate transaction not covered by section 408(b)(1). This transaction would be prohibited under section 406(b)(3) since F would be receiving consideration from a party in interest with respect to a transaction involving plan assets.

Example 5: F is a fiduciary with respect to plan P. D is a party in interest with respect to plan P. Section 406(a)(1)(B) of the Act would prohibit F from causing P to lend money to D. However, F enters into an agreement with Z, a plan participant, where-by F will cause Z to make a participant loan to D with the express understanding that Z will subsequently lend the loan proceeds to D. An examination of Z’s credit standing indicates that he is not creditworthy and would not, under normal circumstances, receive a loan under the conditions established by the participant loan program. F’s decision to approve the participant loan to Z on the basis of Z’s prior agreement to lend the money to D violates the exclusive purpose requirements of sections 408(c) and 404(a). In effect, the entire transaction is viewed as an indirect transfer of plan assets between F and D, and not a loan to a participant exempt under section 408(b)(1). Z’s lack of credit standing would also cause the transaction to fail under section 408(b)(1).

Example 6: F is a fiduciary with respect to Plan P. Z is a plan participant. Z and D are both parties in interest with respect to P. F approves a participant loan to Z in accordance with the conditions established under the participant loan program. Upon receipt of the loan, Z intends to lend the money to D. If F has approved this loan solely upon consideration of those factors which would be considered in a normal commercial setting by an entity in the business of making comparable loans, Z’s subsequent use of the loan proceeds will not affect the determination of whether loans under F’s program satisfy the conditions of section 408(b)(1).

Example 7: A is the trustee of a small individual account plan. D, the president of the plan sponsor, is also a participant in the plan. Pursuant to a participant loan program meeting the requirements of section 408(b)(1), D applies for a loan to be secured by a parcel of real property. D does not intend to repay the loan; rather, upon eventual default, he will permit the property to be foreclosed upon and transferred to the plan in discharge of his legal obligation to repay the loan. A, aware of D’s intention, approves the loan. D fails to make two consecutive quarterly payments of principal and interest under the note evidencing the loan thereby placing the loan in default. The plan then acquires the real property upon foreclosure. Such facts and circumstances indicate that the payment of money from the plan to D was not a participant loan eligible for the relief afforded by section 408(b)(1). In effect, this transaction is a prohibited sale or exchange of property between a plan and a party in interest from the time D receives the money.

Example 8: Plan P establishes a participant loan program. All loans are subject to the condition that the borrowed funds must be used to finance home purchases. Interest rates on the loans are the same as those charged by a local savings and loan association under similar circumstances. A loan by P to a participant to finance a home purchase would be subject to the relief provided by section 408(b)(1) provided that the conditions of 408(b)(1) are met. A participant loan program which is established to make loans for certain stated purposes (e.g., hardship, college tuition, home purchases, etc.) but which is not otherwise designed to benefit parties in interest (other than plan participants) would not, in itself, cause such program to be ineligible for the relief provided.
by section 408(b)(1). However, fiduciaries are cautioned that operation of a loan program with limitations may result in loans not being made available to all participants and beneficiaries on a reasonably equivalent basis.

(b) **Reasonably equivalent basis.** (1) Loans will not be considered to have been made available to participants and beneficiaries on a reasonably equivalent basis unless:

(i) Such loans are available to all plan participants and beneficiaries without regard to any individual’s race, color, religion, sex, age or national origin;

(ii) In making such loans, consideration has been given only to those factors which would be considered in a normal commercial setting by an entity in the business of making similar types of loans. Such factors may include the applicant’s creditworthiness and financial need; and

(iii) An evaluation of all relevant facts and circumstances indicates that, in actual practice, loans are not unreasonably withheld from any applicant.

(2) A participant loan program will not fail the requirement of paragraph (b)(1) of this section or §2550.408b–1(c) if the program establishes a minimum loan amount of up to $1,000, provided that the loans granted meet the requirements of §2550.408b–1(f).

(3) **Examples.** The following examples illustrate the provisions of §2550.408b–1(b)(1):

*Example 1:* T, a trustee of plan P, has exclusive discretion over the management and disposition of plan assets. T’s duties include the administration of a participant loan program which meets the requirements of section 408(b)(1) of the Act. T receives a participant loan at a lower interest rate than the rate made available to other plan participants of similar financial condition or creditworthiness with similar security. The loan by P to T would not be covered by the relief provided by section 408(b)(1), because loans under P’s program are not available to all plan participants and beneficiaries on a reasonably equivalent basis.

*Example 2:* Same facts as in example 1, except that T is a member of a committee of trustees responsible for approving participant loans. T pressures the committee to refuse loans to other qualified participants in order to assure that the assets allocated to the participant loan program would be available for a loan by P to T. The loan by P to T would not be covered by the relief provided by section 408(b)(1) since participant loans have not been made available to all participants and beneficiaries on a reasonably equivalent basis.

*Example 3:* T is the trustee of plan P, which covers the employees of E, A, B and C are employees of E, participants in P, and friends of T. The documents governing P provide that T, in his discretion, may establish a participant loan program meeting certain specified criteria. T institutes such a program and tells A, B and C of his decision. Before T is able to notify P’s other participants and beneficiaries of the loan program, A, B, and C file loan applications which, if approved, will use up substantially all of the funds set aside for the loan program. Approval of these applications by T would represent facts and circumstances showing that loans under P’s program are not available to all participants and beneficiaries on a reasonably equivalent basis.

(c) **Highly compensated employees.** (1) Loans will not be considered to be made available to highly compensated employees, officers or shareholders in an amount greater than the amount made available to other employees if, upon consideration of all relevant facts and circumstances, the program does not operate to exclude large numbers of plan participants from receiving loans under the program.

(2) A participant loan program will not fail to meet the requirement in paragraph (c)(1) of this section, merely because the plan documents specifically governing such loans set forth either (i) a maximum dollar limitation, or (ii) a maximum percentage of vested accrued benefit which no loan may exceed.

(3) If the second alternative in paragraph (c)(2) of this section (maximum percentage of vested accrued benefit) is chosen, a loan program will not fail to meet this requirement solely because maximum loan amounts will vary directly with the size of the participant’s accrued benefit.

(4) **Examples.** The following examples illustrate the provisions of §2550.408b–1(c).

*Example 1:* The documents governing plan P provide for the establishment of a participant loan program in which the amount of any loan under the program (when added to the outstanding balances of any other loans under the program to the same participant) does not exceed the lesser of (i) $50,000, or (ii) one-half of the present value of that participant’s vested accrued benefit under the plan (but not less than $10,000). P’s participant
loan program does not fail to meet the requirement in section 408(b)(1)(B) of the Act, and would be covered by the relief provided by section 408(b)(1) if the other conditions of that section are met.

Example 2: The documents governing plan T provide for the establishment of a participant loan program in which the minimum loan amount would be $25,000. The documents also require that the only security acceptable under the program would be the participant’s vested accrued benefit. A, the plan fiduciary administering the loan program, finds that because of the restrictions in the plan documents only 20 percent of the plan participants, all of whom earn in excess of $75,000 a year, would meet the threshold qualifications for a loan. Most of these participants are high-level supervisors or corporate officers. Based on these facts, it appears that loans under the program would be made available to highly compensated employees in an amount greater than the amount made available to other employees. As a result, the loan program would fail to meet the requirement in section 408(b)(1)(B) of the Act and would not be covered by the relief provided in section 408(b)(1).

(d) Specific plan provisions. For the purpose of section 408(b)(1) and this regulation, the Department will consider that participant loans granted or renewed at any time prior to the last day of the first plan year beginning on or after January 1, 1989, are made in accordance with specific provisions regarding such loans set forth in the plan if:

(1) The plan provisions regarding such loans contain (at a minimum) an explicit authorization for the plan fiduciary responsible for investing plan assets to establish a participant loan program; and

(2) For participant loans granted or renewed on or after the last day of the first plan year beginning on or after January 1, 1989, the participant loan program which is contained in the plan or in a written document forming part of the plan includes, but need not be limited to, the following:

(i) The identity of the person or positions authorized to administer the participant loan program;

(ii) A procedure for applying for loans;

(iii) The basis on which loans will be approved or denied;

(iv) Limitations (if any) on the types and amount of loans offered;

(v) The procedure under the program for determining a reasonable rate of interest;

(vi) The types of collateral which may secure a participant loan; and

(vii) The events constituting default and the steps that will be taken to preserve plan assets in the event of such default.

Example 1: Plan P authorizes the trustee to establish a participant loan program in accordance with section 408(b)(1) of the Act. Pursuant to this explicit authority, the trustee establishes a written program which contains all of the information required by §2550.408b–1(d)(2). Loans made pursuant to this authorization and the written loan program will not fail under section 408(b)(1)(C) of the Act merely because the specific provisions regarding such loans are contained in a separate document forming part of the plan. The specific provisions describing the loan program, whether contained in the plan or in a written document forming part of a plan, do affect the rights and obligations of the participants and beneficiaries under the plan and, therefore, must in accordance with section 102(a)(1) of the Act, be disclosed in the plan’s summary plan description.

(e) Reasonable rate of interest. A loan will be considered to bear a reasonable rate of interest if such loan provides the plan with a return commensurate with the interest rates charged by persons in the business of lending money for loans which would be made under similar circumstances.

Example 1: Plan P makes a participant loan to A at the fixed interest rate of 8% for 5 years. The trustees, prior to making the loan, contacted two local banks to determine under what terms the banks would make a similar loan taking into account A’s credit-worthiness and the collateral offered. One bank would charge a fixed rate of 12% under similar circumstances. Under these facts, the loan to A would not bear a reasonable rate of interest because the loan did not provide P with a return commensurate with interest rates charged by persons in the business of lending money for loans which would be made under similar circumstances. As a result, the loan would fail to meet the requirements of section 408(b)(1)(D) and would not be covered by the relief provided by section 408(b)(1) of the Act.

Example 2: Pursuant to the provisions of plan P’s participant loan program, T, the trustee of P, approves a loan to M, a participant and party in interest with respect to P. At the time of execution, the loan meets all
of the requirements of section 408(b)(1) of the Act. The loan agreement provides that at the end of two years M must pay the remaining balance in full or the parties may renew for an additional two year period. At the end of the initial two year period, the parties agree to renew the loan for an additional two years. At the time of renewal, however, A fails to adjust the interest rate charged on the loan in order to reflect current economic conditions. As a result, the interest rate on the renewal fails to provide a "reasonable rate of interest" as required by section 408(b)(1)(D) of the Act. Under such circumstances, the loan would not be exempt under section 408(b)(1) of the Act from the time of renewal.

Example 3: The documents governing plan P's participant loan program provide that loans must bear an interest rate no higher than the maximum interest rate permitted under State X's usury law. Pursuant to the loan program, P makes a participant loan to A, a plan participant, at a time when the interest rates charged by financial institutions in the community (not subject to the usury limit) for similar loans are higher than the usury limit. Under these circumstances, the loan would not bear a reasonable rate of interest because the loan does not provide P with a return commensurate with the interest rates charged by persons in the business of lending money under similar circumstances. In addition, participant loans that are artificially limited to the maximum usury ceiling then prevailing call into question the status of such loans under sections 403(c) and 404(a) where higher yielding comparable investment opportunities are available to the plan.

(f) Adequate security. (1) A loan will be considered to be adequately secured if the security posted for such loan is something in addition to and supporting a promise to pay, which is so pledged to the plan that it may be sold, foreclosed upon, or otherwise disposed of upon default of repayment of the loan. The value and liquidity of which security is such that it may reasonably be anticipated that loss of principal or interest will not result from the loan. The adequacy of such security will be determined in light of the type and amount of security which would be required in the case of an otherwise identical transaction in a normal commercial setting between unrelated parties on arm's-length terms. A participant's vested accrued benefit under a plan may be used as security for a participant loan to the extent of the plan's ability to satisfy the participant's outstanding obligation in the event of default.

(2) For purposes of this paragraph, (i) No more than 50% of the present value of a participant's vested accrued benefit may be considered by a plan as security for the outstanding balance of all plan loans made to that participant; (ii) A plan will be in compliance with paragraph (f)(2)(i) of this section if, with respect to any participant, it meets the provisions of paragraph (f)(2)(i) of this section immediately after the origination of each participant loan secured in whole or in part by that participant's vested accrued benefit; and

(iii) Any loan secured in whole or in part by a portion of a participant's vested accrued benefit must also meet the requirements of paragraph (f)(1) of this section.

(g) Effective date. This section is effective for all participant loans granted or renewed after October 18, 1989, except with respect to paragraph (d)(2) of this section relating to specific plan provisions. Paragraph (d)(2) of this section is effective for participant loans granted or renewed on or after the last day of the first plan year beginning on or after January 1, 1989. (Approved by the Office of Management and Budget under control number 1219-0076)

[54 FR 30528, July 20, 1989]

§2550.408b–2 General statutory exemption for services or office space.

(a) In general. Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406(a) of the Act payment by a plan to a party in interest, including a fiduciary, for office space or any service (or a combination of services) if:

(1) Such office space or service is necessary for the establishment or operation of the plan;
(2) Such office space or service is furnished under a contract or arrangement which is reasonable; and
(3) No more than reasonable compensation is paid for such office space or service.

However, section 408(b)(2) does not contain an exemption from acts described in section 406(b)(1) of the Act (relating
to fiduciaries dealing with the assets of plans in their own interest or for their own account), section 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries) or section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the assets of the plan). Such acts are separate transactions not described in section 408(b)(2). See §2550.408b-2 (e) and (f) for guidance as to whether transactions relating to the furnishing of office space or services by fiduciaries to plans involve acts described in section 406(b)(1) of the Act. Section 408(b)(2) of the Act does not contain an exemption from other provisions of the Act, such as section 404, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 408(b)(2). See, for example, section 401 of the Internal Revenue Code of 1954. The provisions of section 408(b)(2) of the Act are further limited by section 408(d) of the Act (relating to transactions with owner-employees and related persons).

(b) Necessary service. A service is necessary for the establishment or operation of a plan within the meaning of section 408(b)(2) of the Act and §2550.408b-2(a)(1) if the service is appropriate and helpful to the plan obtaining the service in carrying out the purposes for which the plan is established or maintained. A person providing such a service to a plan (or a person who is a party in interest solely by reason of a relationship to such a service provider described in section 3(14)(F), (G), (H), or (I) of the Act) may furnish goods which are necessary for the establishment or operation of the plan in the course of, and incidental to, the furnishing of such service to the plan.

(c) Reasonable contract or arrangement—(1) Pension plan disclosure.

(i) General. No contract or arrangement for services between a covered plan and a covered service provider, nor any extension or renewal, is reasonable within the meaning of section 408(b)(2) of the Act and paragraph (a)(2) of this section unless the requirements of this paragraph (c)(1) are satisfied. The requirements of this paragraph (c)(1) are independent of fiduciary obligations under section 404 of the Act.

(ii) Covered plan. For purposes of this paragraph (c)(1), a “covered plan” is an “employee pension benefit plan” or a “pension plan” within the meaning of section 3(2)(A) (and not described in section 4(b)) of the Act, except that the term “covered plan” shall not include a “simplified employee pension” described in section 408(k) of the Internal Revenue Code of 1986 (the Code); a “simple retirement account” described in section 408(p) of the Code; an individual retirement account described in section 408(a) of the Code; an individual retirement annuity described in section 408(b) of the Code; or annuity contracts and custodial accounts described in section 403(b) of the Code issued to a current or former employee before January 1, 2009, for which the employer ceased to have any obligation to make contributions (including employee salary reduction contributions), and in fact ceased making contributions to the contract or account for periods before January 1, 2009, and for which all of the rights and benefits under the contract or account are legally enforceable against the insurer or custodian by the individual owner of the contract or account without any involvement by the employer, and for which such individual owner is fully vested in the contract or account.

(iii) Covered service provider. For purposes of this paragraph (c)(1), a “covered service provider” is a service provider that enters into a contract or arrangement with the covered plan and reasonably expects $1,000 or more in compensation, direct or indirect, to be received in connection with providing one or more of the services described in paragraphs (c)(1)(i)(A), (B), or (C) of this section pursuant to the contract or arrangement, regardless of whether such services will be performed, or such compensation received, by the covered service provider, an affiliate, or a subcontractor.
§ 2550.408b-2  

(A) Services as a fiduciary or registered investment adviser.  

(1) Services provided directly to the covered plan as a fiduciary (unless otherwise specified, a “fiduciary” in this paragraph (c)(1) is a fiduciary within the meaning of section 3(21) of the Act);  

(2) Services provided as a fiduciary to an investment contract, product, or entity that holds plan assets (as determined pursuant to sections 3(42) and 401 of the Act and 29 CFR 2510.3-101) and in which the covered plan has a direct equity investment (a direct equity investment does not include investments made by the investment contract, product, or entity in which the covered plan invests); or  

(3) Services provided directly to the covered plan as an investment adviser registered under either the Investment Advisers Act of 1940 or any State law.  

(B) Certain recordkeeping or brokerage services. Recordkeeping services or brokerage services provided to a covered plan that is an individual account plan, as defined in section 3(34) of the Act, and that permits participants or beneficiaries to direct the investment of their accounts, if one or more designated investment alternatives will be made available (e.g., through a platform or similar mechanism) in connection with such recordkeeping services or brokerage services.  

(C) Other services for indirect compensation. Accounting, auditing, actuarial, appraisal, banking, consulting (i.e., consulting related to the development or implementation of investment policies or objectives, or the selection or monitoring of service providers or plan investments), custodial, insurance investment advisory (for plan or participants), legal, recordkeeping, securities or other investment brokerage, third party administration, or valuation services provided to the covered plan, for which the covered service provider, an affiliate, or a subcontractor reasonably expects to receive indirect compensation (as defined in paragraph (c)(1)(viii)(B)(2) of this section or compensation described in paragraph (c)(1)(iv)(C)(3) of this section).  

(D) Limitations. Notwithstanding paragraphs (c)(1)(iii)(A), (B), or (C) of this section, no person or entity is a “covered service provider” solely by providing services—  

(1) As an affiliate or a subcontractor that is performing one or more of the services described in paragraphs (c)(1)(ii)(A), (B), or (C) of this section under the contract or arrangement with the covered plan; or  

(2) To an investment contract, product, or entity in which the covered plan invests, regardless of whether or not the investment contract, product, or entity holds assets of the covered plan, other than services as a fiduciary described in paragraph (c)(1)(iii)(A)(2) of this section.  

(iv) Initial disclosure requirements. The covered service provider must disclose the following information to a responsible plan fiduciary, in writing—  

(A) Services. A description of the services to be provided to the covered plan pursuant to the contract or arrangement (but not including non-fiduciary services described in paragraph (c)(3)(iii)(D)(2) of this section).  

(B) Status. If applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan (or to an investment contract, product or entity that holds plan assets and in which the covered plan has a direct equity investment) as a fiduciary (within the meaning of section 3(21) of the Act); and, if applicable, a statement that the covered service provider, an affiliate, or a subcontractor will provide, or reasonably expects to provide, services pursuant to the contract or arrangement directly to the covered plan as an investment adviser registered under either the Investment Advisers Act of 1940 or any State law.  

(C) Compensation—(1) Direct compensation. A description of all direct compensation (as defined in paragraph (c)(1)(viii)(B)(1) of this section), either in the aggregate or by service, that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with the services described pursuant to paragraph (c)(1)(iv)(A) of this section.  

(2) Indirect compensation. A description of all indirect compensation (as defined in paragraph (c)(1)(viii)(B)(2) of this section).
this section) that the covered service provider, an affiliate, or a sub-contractor reasonably expects to receive in connection with the services described pursuant to paragraph (c)(1)(iv)(A) of this section; including identification of the services for which the indirect compensation will be received, identification of the payer of the indirect compensation, and a description of the arrangement between the payer and the covered service provider, an affiliate, or a subcontractor, as applicable, pursuant to which such indirect compensation is paid.

(3) Compensation paid among related parties. A description of any compensation that will be paid among the covered service provider, an affiliate, or a subcontractor, in connection with the services described pursuant to paragraph (c)(1)(iv)(A) of this section if it is set on a transaction basis (e.g., commissions, soft dollars, finder’s fees or other similar incentive compensation based on business placed or retained) or is charged directly against the covered plan’s investment and reflected in the net value of the investment (e.g., Rule 12b-1 fees); including identification of the services for which such compensation will be paid and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or a subcontractor). Compensation must be disclosed pursuant to this paragraph (c)(1)(iv)(C)(3) regardless of whether such compensation also is disclosed pursuant to paragraph (c)(1)(iv)(C)(1) or (2), (c)(1)(iv)(E), or (c)(1)(iv)(F) of this section. This paragraph (c)(1)(iv)(C)(3) shall not apply to compensation received by an employee from his or her employer on account of work performed by the employee.

(4) Compensation for termination of contract or arrangement. A description of any compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.

(D) Recordkeeping services. Without regard to the disclosure of compensation pursuant to paragraph (c)(1)(iv)(C), (c)(1)(iv)(E), or (c)(1)(iv)(F) of this section, if recordkeeping services will be provided to the covered plan—

(1) A description of all direct and indirect compensation that the covered service provider, an affiliate, or a subcontractor reasonably expects to receive in connection with such recordkeeping services; and

(2) If the covered service provider reasonably expects recordkeeping services to be provided, in whole or in part, without explicit compensation for such recordkeeping services, or when compensation for recordkeeping services is offset or rebated based on other compensation received by the covered service provider, an affiliate, or a subcontractor, a reasonable and good faith estimate of the cost to the covered plan of such recordkeeping services, including an explanation of the methodology and assumptions used to prepare the estimate and a detailed explanation of the recordkeeping services that will be provided to the covered plan. The estimate shall take into account, as applicable, the rates that the covered service provider, an affiliate, or a subcontractor would charge to, or be paid by, third parties, or the prevailing market rates charged, for similar recordkeeping services for a similar plan with a similar number of covered participants and beneficiaries.

(E) Investment disclosure—fiduciary services. In the case of a covered service provider described in paragraph (c)(3)(iii)(A)(2) of this section, the following additional information with respect to each investment contract, product, or entity that holds plan assets and in which the covered plan has a direct equity investment, and for which fiduciary services will be provided pursuant to the contract or arrangement with the covered plan, unless such information is disclosed to the responsible plan fiduciary by a covered service provider providing recordkeeping services or brokerage services as described in paragraph (c)(1)(ii)(B) of this section—

(1) A description of any compensation that will be charged directly against an investment, such as commissions, sales loads, sales charges, deferred sales charges, redemption fees, surrender charges, exchange fees, account fees,
and purchase fees; and that is not included in the annual operating expenses of the investment contract, product, or entity;

(2) A description of the annual operating expenses (e.g., expense ratio) if the return is not fixed and any ongoing expenses in addition to annual operating expenses (e.g., wrap fees, mortality and expense fees), or, for an investment contract, product, or entity that is a designated investment alternative, the total annual operating expenses expressed as a percentage and calculated in accordance with 29 CFR 2550.404a–5(h)(5); and

(3) For an investment contract, product, or entity that is a designated investment alternative, any other information or data about the designated investment alternative that is within the control of, or reasonably available to, the covered service provider and that is required for the covered plan administrator to comply with the disclosure obligations described in 29 CFR 2550.404a–5(d)(1).

(F) Investment disclosure—record-keeping and brokerage services.

(1) In the case of a covered service provider described in paragraph (c)(1)(iii)(B) of this section, the additional information described in paragraph (c)(1)(iv)(E)(I) through (J) of this section with respect to each designated investment alternative for which recordkeeping services or brokerage services as described in paragraph (c)(1)(iv)(E) of this section will be provided pursuant to the contract or arrangement with the covered plan.

(2) A covered service provider may comply with this paragraph (c)(1)(iv)(F) by providing current disclosure materials of the issuer of the designated investment alternative, or information replicated from such materials, that include the information described in such paragraph, provided that:

(i) The issuer is not an affiliate;

(ii) The issuer is a registered investment company, an insurance company qualified to do business in any State, an issuer of a publicly traded security, or a financial institution supervised by a State or federal agency; and

(iii) The covered service provider acts in good faith and does not know that the materials are incomplete or inaccurate, and furnishes the responsible plan fiduciary with a statement that the covered service provider is making no representations as to the completeness or accuracy of such materials.

(G) Manner of receipt. A description of the manner in which the compensation described in paragraph (c)(1)(iv)(C) through (F) of this section, as applicable, will be received, such as whether the covered plan will be billed or the compensation will be deducted directly from the covered plan’s account(s) or investments.

(H) Guide to initial disclosures. [Reserved]

(v) Timing of initial disclosure requirements; changes.

(A) A covered service provider must disclose the information required by paragraph (c)(1)(iv) of this section to the responsible plan fiduciary reasonably in advance of the date the contract or arrangement is entered into, and extended or renewed, except that—

(1) When an investment contract, product, or entity is determined not to hold plan assets upon the covered plan’s direct equity investment, but subsequently is determined to hold plan assets while the covered plan’s investment continues, the information required by paragraph (c)(1)(iv) of this section must be disclosed as soon as practicable, but not later than 30 days from the date on which the covered service provider knows that such investment contract, product, or entity holds plan assets; and

(2) The information described in paragraph (c)(1)(iv)(F) of this section relating to any investment alternative that is not designated at the time the contract or arrangement is entered into must be disclosed as soon as practicable, but not later than the date the investment alternative is designated by the covered plan.

(B) (i) A covered service provider must disclose a change to the information required by paragraph (c)(1)(iv)(A) through (D), and (G) of this section as soon as practicable, but not later than 60 days from the date on which the covered service provider is informed of such change, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider.
provider’s control, in which case the information must be disclosed as soon as practicable.

(2) A covered service provider must, at least annually, disclose any changes to the information required by paragraph (c)(1)(iv)(E) and (F) of this section.

(vi) Reporting and disclosure information; timing.

(A) Upon the written request of the responsible plan fiduciary or covered plan administrator, the covered service provider must furnish any other information relating to the compensation received in connection with the contract or arrangement that is required for the covered plan to comply with the reporting and disclosure requirements of Title I of the Act and the regulations, forms and schedules issued thereunder.

(B) The covered service provider must disclose the information required by paragraph (c)(1)(vi)(A) of this section reasonably in advance of the date upon which such responsible plan fiduciary or covered plan administrator states that it must comply with the applicable reporting or disclosure requirement, unless such disclosure is precluded due to extraordinary circumstances beyond the covered service provider’s control, in which case the information must be disclosed as soon as practicable.

(vii) Disclosure errors. No contract or arrangement will fail to be reasonable under this paragraph (c)(1) solely because the covered service provider, acting in good faith and with reasonable diligence, makes an error or omission in disclosing the information required pursuant to paragraph (c)(1)(iv) of this section (or a change to such information disclosed pursuant to paragraph (c)(1)(v)(B) of this section) or paragraph (c)(1)(vi) of this section, provided that the covered service provider discloses the correct information to the responsible plan fiduciary as soon as practicable, but not later than 30 days from the date on which the covered service provider knows of such error or omission.

(viii) Definitions. For purposes of paragraph (c)(1) of this section:

(A) Affiliate. A person’s or entity’s “affiliate” directly or indirectly (through one or more intermediaries) controls, is controlled by, or is under common control with such person or entity; or is an officer, director, or employee of, or partner in, such person or entity. Unless otherwise specified, an “affiliate” in this paragraph (c)(1) refers to an affiliate of the covered service provider.

(B) Compensation. Compensation is anything of monetary value (for example, money, gifts, awards, and trips), but does not include non-monetary compensation valued at $250 or less, in the aggregate, during the term of the contract or arrangement.

(1) “Direct” compensation is compensation received directly from the covered plan.

(2) “Indirect” compensation is compensation received from any source other than the covered plan, the plan sponsor, the covered service provider, or an affiliate. Compensation received from a subcontractor is indirect compensation, unless it is received in connection with services performed under the subcontractor’s contract or arrangement described in paragraph (c)(1)(viii)(F) of this section.

(3) A description of compensation or cost may be expressed as a monetary amount, formula, percentage of the covered plan’s assets, or a per capita charge for each participant or beneficiary or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method. The description may include a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and the covered service provider explains the methodology and assumptions used to prepare such estimate. Any description, including any estimate of recordkeeping cost under paragraph (c)(1)(iv)(D), must contain sufficient information to permit evaluation of the reasonableness of the compensation or cost.

(C) Designated investment alternative. A “designated investment alternative” is any investment alternative designated by the covered plan into which participants and beneficiaries may direct the investment of assets held in,
or contributed to, their individual accounts. The term “designated investment alternative” shall not include brokerage windows, self-directed brokerage accounts, or similar plan arrangements that enable participants and beneficiaries to select investments beyond those designated by the covered plan.

(D) **Recordkeeping services.** “Recordkeeping services” include services related to plan administration and monitoring of plan and participant and beneficiary transactions (e.g., enrollment, payroll deductions and contributions), offering designated investment alternatives and other covered plan investments, loans, withdrawals and distributions; and the maintenance of covered plan and participant and beneficiary accounts, records, and statements.

(E) **Responsible plan fiduciary.** A “responsible plan fiduciary” is a fiduciary with authority to cause the covered plan to enter into, or extend or renew, the contract or arrangement.

(F) **Subcontractor.** A “subcontractor” is any person or entity (or an affiliate of such person or entity) that is not an affiliate of the covered service provider and that, pursuant to a contract or arrangement with the covered service provider or an affiliate, reasonably expects to receive $1,000 or more in compensation for performing one or more services described pursuant to paragraph (c)(1)(iii)(A) through (C) of this section provided for by the contract or arrangement with the covered plan.

(ix) **Exemption for responsible plan fiduciary.** Pursuant to section 408(a) of the Act, the restrictions of section 406(a)(1)(C) and (D) of the Act shall not apply to a responsible plan provider or an affiliate, reasonably expects to receive $1,000 or more in compensation for performing one or more services described pursuant to paragraph (c)(1)(i)(A) through (C) of this section provided for by the contract or arrangement with the covered plan.

29 CFR Ch. XXV (7–1–15 Edition)

VerDate Sep<11>2014 11:45 Oct 07, 2015 Jkt 235124 PO 00000 Frm 00668 Fmt 8010 Sfmt 8010 Y:\SGML\235124.XXX 235124Lhorne on DSK5TPTVN1PROD with CFR
(G) If the covered service provider fails to comply with the written request referred to in paragraph (c)(1)(ix)(C) of this section within 90 days of such request, the responsible plan fiduciary shall determine whether to terminate or continue the contract or arrangement consistent with its duty of prudence under section 404 of the Act. If the requested information relates to future services and is not disclosed promptly after the end of the 90-day period, then the responsible plan fiduciary shall terminate the contract or arrangement as expeditiously as possible, consistent with such duty of prudence.

(x) Preemption of State law. Nothing in this section shall be construed to supersede any provision of State law that governs disclosures by parties that provide the services described in this section, except to the extent that such law prevents the application of a requirement of this section.

(xi) Internal Revenue Code. Section 4975(d)(2) of the Code contains provisions parallel to section 408(b)(2) of the Act. Effective December 31, 1978, section 102 of the Reorganization Plan No. 4 of 1978, 5 U.S.C. App. 214 (2000 ed.), transferred the authority of the Secretary of the Treasury to promulgate regulations of the type published hereunder to the Secretary of Labor. All references herein to section 408(b)(2) of the Act and the regulations thereunder should be read to include reference to the parallel provisions of section 4975(d)(2) of the Code and regulations thereunder at 26 CFR 54.4975–6.

(xii) Effective date. Paragraph (c) of this section shall be effective on July 1, 2012. Paragraph (c)(1) of this section shall apply to contracts or arrangements between covered plans and covered service providers as of the effective date, without regard to whether the contract or arrangement was entered into prior to such date; for contracts or arrangements entered into prior to the effective date, the information required to be disclosed pursuant to paragraph (c)(1)(iv) of this section must be furnished no later than the effective date.

(2) Welfare plan disclosure. [Reserved]

(3) Termination of contract or arrangement. No contract or arrangement is reasonable within the meaning of section 408(b)(2) of the Act and paragraph (a)(2) of this section 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 payment in excess of actual loss or if it fails to require mitigation of damages.

(d) Reasonable compensation. Section 408(b)(2) of the Act and §2550.408b–2(a)(3) permit a plan to pay a party in interest reasonable compensation for the provision of office space or services described in section 408(b)(2). Section 2550.408c–2 of these regulations contains provisions relating to what constitutes reasonable compensation for the provision of services.

(e) Transactions with fiduciaries—(1) In general. If the furnishing of office space or a service involves an act described in section 406(b) of the Act (relating to acts involving conflicts of interest by fiduciaries), such an act constitutes a separate transaction which is not exempt under section 408(b)(2) of the Act. The prohibitions of section 406(b) supplement the other prohibitions of section 406(a) of the Act by imposing on parties in interest who are fiduciaries a duty of undivided loyalty to the plans for which they act. These prohibitions are imposed upon fiduciaries to deter
them from exercising the authority, control, or responsibility which makes such persons fiduciaries when they have interests which may conflict with the interests of the plans for which they act. In such cases, the fiduciaries have interests in the transactions which may affect the exercise of their best judgment as fiduciaries. Thus, a fiduciary may not use the authority, control, or responsibility which makes such person a fiduciary to cause a plan to pay an additional fee to such fiduciary (or to a person in which such fiduciary has an interest which may affect the exercise of such fiduciary’s best judgment as a fiduciary) to provide a service. Nor may a fiduciary use such authority, control, or responsibility to cause a plan to enter into a transaction involving plan assets whereby such fiduciary (or a person in which such fiduciary has an interest which may affect the exercise of such fiduciary’s best judgment as a fiduciary) will receive consideration from a third party in connection with such transaction. A person in which a fiduciary has an interest which may affect the exercise of such fiduciary’s best judgment as a fiduciary includes, for example, a person who is a party in interest by reason of a relationship to such fiduciary described in section 3(14)(E), (F), (G), (H), or (I).

(2) Transactions not described in section 406(b)(1). A fiduciary does not engage in an act described in section 406(b)(1) of the Act if the fiduciary does not use any of the authority, control or responsibility which makes such person a fiduciary to cause a plan to pay additional fees for a service furnished by such fiduciary or to pay a fee for a service furnished by a person in which such fiduciary has an interest which may affect the exercise of such fiduciary’s best judgment as a fiduciary. This may occur, for example, when one fiduciary is retained on behalf of a plan by a second fiduciary to provide a service for an additional fee. However, because the authority, control or responsibility which makes a person a fiduciary may be exercised “in effect” as well as in form, mere approval of the transaction by a second fiduciary does not mean that the first fiduciary has not used any of the authority, control or responsibility which makes such person a fiduciary to cause the plan to pay the first fiduciary an additional fee for a service. See paragraph (f) of this section.

(3) Services without compensation. If a fiduciary provides services to a plan without the receipt of compensation or other consideration (other than reimbursement of direct expenses properly and actually incurred in the performance of such services within the meaning of §2550.408c–2(b)(3)), the provision of such services does not, in and of itself, constitute an act described in section 406(b) of the Act. The allowance of a deduction to an employer under section 162 or 212 of the Code for the expense incurred in furnishing office space or services to a plan established or maintained by such employer does not constitute compensation or other consideration.

(4) Examples. The provisions of §2550.408b–2(e) may be illustrated by the following examples.

Example 1. E, an employer whose employees are covered by plan P, is a fiduciary of P. E is a professional investment adviser in which E has no interest which may affect the exercise of E’s best judgment as a fiduciary. E causes P to retain I to provide certain kinds of investment advisory services of a type which causes I to be a fiduciary of P under section 3(21)(A)(ii) of the Act. Thereafter, I proposes to perform for additional fees portfolio evaluation services in addition to the services currently provided. The provision of such services is arranged by I and approved on behalf of the plan by E. I has not engaged in an act described in section 406(b)(1) of the Act, because I did not use any of the authority, control or responsibility which makes I a fiduciary (the provision of investment advisory services) to cause the plan to pay I additional fees for the provision of the portfolio evaluation services. E has not engaged in an act which is described in section 406(b)(1). E, as the fiduciary who has the responsibility to be prudent in his selection and retention of I and the other investment advisers of the plan, has an interest in the purchase by the plan of portfolio evaluation services. However, such an interest is not an interest which may affect the exercise of E’s best judgment as a fiduciary.

Example 2. D, a trustee of plan P with discretion over the management and disposition of plan assets, relies on the advice of C, a consultant to P, as to the investment of plan assets, thereby making C a fiduciary of the plan. On January 1, 1988, C recommends to D that the plan purchase an insurance policy.
from U, an insurance company which is not a party in interest with respect to P. C thoroughly explains the reasons for the recommendation and makes a full disclosure concerning the record that C has received a commission from U upon the purchase of the policy of P. D considers the recommendation and approves the purchase of the policy by P. C receives a commission. Under such circumstances, C has engaged in an act described in section 406(b)(1) of the Act (as well as sections 406(b)(2) and (3) of the Act) because C is in fact exercising the authority, control or responsibility which makes C a fiduciary to cause the plan to purchase the policy. However, the transaction is exempt from the prohibited transaction provisions of section 406 of the Act, if the requirements of Prohibited Transaction Exemption 77–9 are met.

Example 3. Assume the same facts as in Example (2) except that the nature of C’s relationship with the plan is not such that C is a fiduciary of P. The purchase of the insurance policy does not involve an act described in section 406(b)(1) of the Act (or sections 406(b)(2) or (3) of the Act) because such sections only apply to acts by fiduciaries.

Example 4. E, an employer whose employees are covered by plan P, is a fiduciary with respect to P, A, who is not a party in interest with respect to P, persuades E that the plan needs the services of a professional investment adviser and that A should be hired to provide the investment advice. Accordingly, E causes P to hire A to provide investment advice of the type which makes A a fiduciary under §2510.3–21(c)(1)(ii)(B). Prior to the expiration of A’s first contract with P, A persuades E to cause P to renew A’s contract with P to provide the same services for additional fees in view of the increased costs in providing such services. During the period of A’s second contract, A provides additional investment advice services for which no additional charge is made. Prior to the expiration of A’s second contract, A persuades E to cause P to renew his contract for additional fees in view of the additional services A is providing. A has not engaged in an act described in section 406(b)(1) of the Act, because A has not used any of the authority, control or responsibility which makes A a fiduciary (the provision of investment advice) to cause the plan to pay additional fees for A’s services.

Example 5. F, a trustee of plan P with discretion over the management and disposition of plan assets, retains C to provide administrative services to P of the type which makes C a fiduciary under section 3(21)(A)(iii). Thereafter, C retains F to provide for additional fees actuarial and various kinds of administrative services in addition to the services F is currently providing to P. Both F and C have engaged in an act described in section 406(b)(1) of the Act. F, regardless of any intent which he may have had at the time he retained C, has engaged in such an act because F has, in effect, exercised the authority, control or responsibility which makes F a fiduciary to cause the plan to pay F additional fees for the services. C, whose continued employment by P depends on F, has also engaged in such an act, because C has an interest in the transaction which might affect the exercise of C’s best judgment as a fiduciary. As a result, C has dealt with plan assets in his own interest under section 406(b)(1).

Example 6. F, a fiduciary of plan P with discretionary authority respecting the management of P, retains S, the son of F, to provide for a fee various kinds of administrative services necessary for the operation of the plan. F has engaged in an act described in section 406(b)(1) of the Act because S is a person in whom F has an interest which may affect the exercise of F’s best judgment as a fiduciary. Such act is not exempt under section 406(b)(2) of the Act irrespective of whether the provision of the services by S is exempt.

Example 7. T, one of the trustees of plan P, is president of bank B. The bank proposes to provide administrative services to P for a fee. T physically absents himself from all consideration of B’s proposal and does not otherwise exercise any of the authority, control or responsibility which makes T a fiduciary to cause the plan to retain B. The other trustees decide to retain B. T has not engaged in an act described in section 406(b)(1) of the Act. Further, the other trustees have not engaged in an act described in section 406(b)(1) merely because T is on the board of trustees of P. This fact alone would not make them have an interest in the transaction which might affect the exercise of their best judgment as fiduciaries.


§ 2550.408b–3 Loans to Employee Stock Ownership Plans.

(a) Definitions. When used in this section, the terms listed below have the following meanings:

(1) ESOP. The term ESOP refers to an employee stock ownership plan that meets the requirements of section 407(d)(6) of the Employee Retirement Income Security Act of 1974 (the Act) and 29 CFR 2550.407d–6. It is not synonymous with “stock bonus plan.” A stock bonus plan must, however, be an ESOP to engage in an exempt loan. The qualification of an ESOP under section 401 (a) of the Internal Revenue Code (the Code) and 26 CFR 54.4975–11 will

661
not be adversely affected merely because it engages in a non-exempt loan.

(2) Loan. The term loan refers to a loan made to an ESOP by a party in interest or a loan to an ESOP which is guaranteed by a party in interest. It includes a direct loan of cash, a purchase-money transaction, and an assumption of the obligation of an ESOP. “Guarantee” includes an unsecured guarantee and the use of assets of a party in interest as collateral for a loan, even though the use of assets may not be a guarantee under applicable state law. An amendment of a loan in order to qualify as an exempt loan is not a refinancing of the loan or the making of another loan.

(3) Exempt loan. The term exempt loan refers to a loan that satisfies the provisions of this section. A “non-exempt loan” is one that fails to satisfy such provisions.


(5) Qualifying employer security. The term qualifying employer security refers to a security described in 29 CFR 2550.407d-5.

(b) Statutory exemption—(1) Scope. Section 408(b)(3) of the Act provides an exemption from the prohibited transaction provisions of sections 406(a) and 406(b)(1) of the Act (relating to fiduciaries dealing with the assets of plans in their own interest or for their own account) and 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries). Section 408(b)(3) does not provide an exemption from the prohibitions of section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the income or assets of the plan).

(2) Special scrutiny of transaction. The exemption under section 408(b)(3) includes within its scope certain transactions in which the potential for self-dealing by fiduciaries exists and in which the interests of fiduciaries may conflict with the interests of participants. To guard against these potential abuses, the Department of Labor will subject these transactions to special scrutiny to ensure that they are primarily for the benefit of participants and their beneficiaries. Although the transactions need not be arranged and approved by an independent fiduciary, fiduciaries are cautioned to scrupulously exercise their discretion in approving them. For example, fiduciaries should be prepared to demonstrate compliance with the net effect test and the arm’s-length standard under paragraphs (c)(2) and (3) of this section. Also, fiduciaries should determine that the transaction is truly arranged primarily in the interest of participants and their beneficiaries rather than, for example, in the interest of certain selling shareholders.

(c) Primary benefit requirements—(1) In general. An exempt loan must be primarily for the benefit of participants and their beneficiaries. All the surrounding facts and circumstances, including those described in paragraphs (c)(2) and (3) of this section, will be considered in determining whether such loan satisfies this requirement. However, no loan will satisfy such requirement unless it satisfies the requirements of paragraphs (d), (e) and (f) of this section.

(2) Net effect on plan assets. At the time that a loan is made, the interest rate for the loan and the price of securities to be acquired with the loan proceeds should not be such that plan assets might be drained off.

(3) Arm’s-length standard. The terms of a loan, whether or not between independent parties, must, at the time the loan is made, be at least as favorable to the ESOP as the terms of a comparable loan resulting from arm’s-length negotiations between independent parties.

(d) Use of loan proceeds. The proceeds of an exempt loan must be used, within a reasonable time after their receipt,
by the borrowing ESOP only for any or all of the following purposes:

(1) To acquire qualifying employer securities.

(2) To repay such loan.

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

Except as provided in paragraphs (i) and (j) of this section or as otherwise required by applicable law, no security acquired with the proceeds of an exempt loan may be subject to a put, call, or other option, or buy-sell or similar arrangement while held by and when distributed from a plan, whether or not the plan is then ESOP.

(e) Liability and collateral of ESOP for loan. An exempt loan must be without recourse against the ESOP. Furthermore, the only assets of the ESOP that may be given as collateral on an exempt loan are qualifying employer securities of two classes: Those acquired with the proceeds of the exempt loan and those that were used as collateral on a prior exempt loan repaid with the proceeds of the current exempt loan. No person entitled to payment under the exempt loan shall have any right to assets of the ESOP other than:

(1) Collateral given for the loan.

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

(3) Earnings attributable to such collateral and the investment of such contributions.

The payments made with respect to an exempt loan by the ESOP during a plan year must not exceed an amount equal to the sum of such contributions and earnings received during or prior to the year less such payments in prior years. Such contributions and earnings must be accounted for separately in the books of account of the ESOP until the loan is repaid.

(1) Default. In the event of default upon an exempt loan, the value of plan assets transferred in satisfaction of the loan must not exceed the amount of default. If the lender is a party in interest, a loan must provide for a transfer of plan assets upon default only upon and to the extent of the failure of the plan to meet the payment schedule of the loan. For purposes of this paragraph, the making of a guarantee does not make a person a lender.

(g) Reasonable rate of interest. The interest rate of a loan must not be in excess of a reasonable rate of interest. All relevant factors will be considered in determining a reasonable rate of interest, including the amount and duration of the loan, the security and guarantor (if any) involved, the credit standing of the ESOP and the guarantor (if any), and the interest rate prevailing for comparable loans. When these factors are considered, a variable interest rate may be reasonable.

(h) Release from encumbrance—(1) General rule. In general, an exempt loan must provide for the release from encumbrance of plan assets used as collateral for the loan under this paragraph. For each plan year during the duration of the loan, the number of securities released must equal the number of encumbered securities held immediately before release for the current plan year multiplied by a fraction. The numerator of the fraction is the amount of principal and interest paid for the year. The denominator of the fraction is the sum of the numerator plus the principal and interest to be paid for all future years. See §2550.408b-3(h)(4). The number of future years under the loan must be definitely ascertainable and must be determined without taking into account any possible extensions or renewal periods. If the interest rate under the loan is variable, the interest to be paid in future years must be computed by using the interest rate applicable as of the end of the plan year. If collateral includes more than one class of securities, the number of securities of each class to be released for a plan year must be determined by applying the same fraction to each class.

(2) Special rule. A loan will not fail to be exempt merely because the number of securities to be released from encumbrance is determined solely with reference to principal payments. However, if release is determined with reference to principal payments only, the following three additional rules apply. The first rule is that the loan must provide for annual payments of principal and interest at a cumulative rate.
§ 2550.408b-3  

29 CFR Ch. XXV (7–1–15 Edition)  

that is not less rapid at any time than level annual payments of such amounts for 10 years. The second rule is that interest included in any payment is disregarded only to the extent that it would be determined to be interest under standard loan amortization tables. The third rule is that subdivision (2) is not applicable from the time that, by reason of a renewal, extension, or refinancing, the sum of the expired duration of the exempt loan, the renewal period, the extension period, and the duration of a new exempt loan exceeds 10 years.

(3) Caution against plan disqualification. Under an exempt loan, the number of securities released from encumbrance may vary from year to year. The release of securities depends upon certain employer contributions and earnings under the ESOP. Under 26 CFR 54.4975–11(d)(2) actual allocations to participants’ accounts are based upon assets withdrawn from the suspense account. Nevertheless, for purposes of applying the limitations under section 415 of the Code to these allocations, under 26 CFR 54.4975–11(a)(8)(i) contributions used by the ESOP to pay the loan are treated as annual additions to participants’ accounts. Therefore, particular caution must be exercised to avoid exceeding the maximum annual additions under section 415 of the Code. At the same time, release from encumbrance in annually varying numbers may reflect a failure on the part of the employer to make substantial and recurring contributions to the ESOP which will lead to loss of qualification under section 401(a) of the Code. The Internal Revenue Service will observe closely the operation of ESOPs that release encumbered securities. The third rule is that subdivision (j) 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.

(4) Illustration. The general rule under paragraph (b)(1) of this section operates as illustrated in the following examples:

Example. Corporation X establishes an ESOP that borrows $750,000 from a bank. X guarantees the loan which is for 15 years at 5% interest and is payable in level annual amounts of $72,256.72. Total payments on the loan are $1,083,850.80. The ESOP uses the entire proceeds of the loan to acquire 15,000 shares of X stock which is used as collateral for the loan. The number of securities to be released for the first year is 1,000 shares, i.e., 15,000 shares \( \times \frac{72,256.72}{1,083,850.80} = 15,000 \) shares \( \times \frac{1}{15} \). The number of securities to be released for the second year is 1,000 shares, i.e., 14,000 shares \( \times \frac{72,256.72}{1,011,594.08} = 14,000 \) shares \( \times \frac{1}{14} \). If all loan payments are made as originally scheduled, the number of securities released in each succeeding year of the loan will also be 1,000.

(i) Right of first refusal. Qualifying employer securities acquired with proceeds of an exempt loan may, but need not, be subject to a right of first refusal. However, any such right must meet the requirements of this paragraph. Securities subject to such right must be stock or an equity security, or a debt security convertible into stock or an equity security. Also, they must not be publicly traded at the time the right may be exercised. The right of first refusal must be in favor of the employer, the ESOP, or both in any order of priority. The selling price and other terms under the right must not be less favorable to the seller than the greater of the value of the security determined under 26 CFR 54.4975–11(d)(5), or the purchase price and other terms offered by a buyer, other than the employer or the ESOP, making a good faith offer to purchase the security. The right of first refusal must lapse no later than 14 days after the security holder gives written notice to the holder of the right that an offer by a third party to purchase the security has been received.

(j) Put option. A qualifying employer security acquired with the proceeds of an exempt loan by an ESOP after September 30, 1976, must be subject to a put option if it is not publicly traded when distributed or if it is subject to a trading limitation when distributed. For purposes of this paragraph, a “trading limitation” or a security is a restriction under any Federal or State securities law or any regulation thereunder, or an agreement (not prohibited by this section) affecting the security which would make the security not as freely tradeable as one not subject to such restriction. The put option must be exercisable only by a participant, by the participant’s donees, or by a person
(including an estate or its distributee) to whom the security passes by reason of a participant’s death. (Under this paragraph “participant” means a participant and the beneficiaries of the participant under the ESOP.) The put option must permit a participant to put the security to the employer. Under no circumstances may the put option bind the ESOP. However, it may grant the ESOP an option to assume the rights and obligations of the employer at the time that the put option is exercised. If it is known at the time a loan is made that Federal or state law will be violated by the employer’s honoring such put option, the put option must permit the security to be put, in a manner consistent with such law, to a third party (e.g., an affiliate of the employer or a shareholder other than the ESOP) that has substantial net worth at the time the loan is made and whose net worth is reasonably expected to remain substantial.

(k) **Duration of put option**—(1) **General rule.** A put option must be exercisable at least during a 15-month period which begins the date the security subject to the put option is distributed by the ESOP.

(2) **Special rule.** In the case of a security that is publicly traded without restriction when distributed but ceases to be so traded within 15 months after distribution, the employer must notify each security holder in writing on or before the tenth day after the date the security ceases to be so traded that for the remainder of the 15-month period the security is subject to a put option. The number of days between the tenth day and the date on which notice is actually given, if later than the tenth day, must be added to the duration of the put option. The notice must inform distributees of the terms of the put options that they are to hold. The terms must satisfy the requirements of paragraphs (j) through (l) of this section.

(1) **Other put option provisions.**—(1) **Manner of exercise.** A put option is exercised by the holder notifying the employer in writing that the put option is being exercised.

(2) **Time excluded from duration of put option.** The period during which a put option is exercisable does not include any time when a distributee is unable to exercise it because the party bound by the put option is prohibited from honoring it by applicable Federal or State law.

(3) **Price.** The price at which a put option must be exercisable is the value of the security, determined in accordance with paragraph (d)(5) of 26 CFR 54.4975-11.

(4) **Payment terms.** The provisions for payment under a put option must be reasonable. The deferral of payment is reasonable if adequate security and a reasonable interest rate are provided for any credit extended and if the cumulative payments at any time are no less than the aggregate of reasonable periodic payments as of such time. Periodic payments are reasonable if annual installments, beginning with 30 days after the date the put option is exercised, are substantially equal. Generally, the payment period may not end more than 5 years after the date the put option is exercised. However, it may be extended to a date no later than the earlier of 10 years from the date the put option is exercised or the date the proceeds of the loan used by the ESOP to acquire the security subject to the put option are entirely repaid.

(5) **Payment restrictions.** Payment under a put option may be restricted by the terms of a loan, including one used to acquire a security subject to a put option, made before November 1, 1977. Otherwise, payment under a put option must not be restricted by the provisions of a loan or any other arrangement, including the terms of the employer’s articles of incorporation, unless so required by applicable state law.

(m) **Other terms of loan.** An exempt loan must be for a specific term. Such loan may not be payable at the demand of any person, except in the case of default.

(n) **Status of plan as ESOP.** To be exempt, a loan must be made to a plan that is an ESOP at the time of such loan. However, a loan to a plan formally designated as an ESOP at the time of the loan that fails to be an ESOP because it does not comply with section 401(a) of the Code or 26 CFR 54.4975-11 will be exempt as of the time of such loan if the plan is amended.
§2550.408b–4 Statutory exemption for investments in deposits of banks or similar financial institutions.

(a) In general. Section 408(b)(4) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406 of the Act the investment of all or a part of a plan’s assets in deposits bearing a reasonable rate of interest in a bank or similar financial institution supervised by the United States or a State, even though such bank or similar financial institution is a fiduciary or other party in interest with respect to the plan, if the conditions of either §2550.408b–4(b)(1) or §2550.408b–4(b)(2) are met. Section 408(b)(4) provides an exemption from sections 406(b)(1) of the Act (relating to fiduciaries dealing with the assets of plans in their own interest or for their own account) and 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries), as well as section 406(a)(1), because section 408(b)(4) contemplates a bank or similar financial institution causing a plan for which it acts as a fiduciary to invest plan assets in its own deposits if the requirements of section 408(b)(4) are met. However, it does not provide an exemption from section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the assets of the plan). The receipt of such consideration is a separate transaction not
described in the statutory exemption. Section 408(b)(4) does not contain an exemption from other provisions of the Act, such as section 404, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 408(b)(4) of the Act. See, for example, section 401 of the Internal Revenue Code of 1954 (Code). The provisions of section 408(b)(4) of the Act are further limited by section 408(d) of the Act (relating to transactions with owner-employees and related persons).

(b)(1) Plan covering own employees. Such investment may be made if the plan is one which covers only the employees of the bank or similar financial institution, the employees of any of its affiliates, or the employees of both.

(2) Other plans. Such investment may be made if the investment is expressly authorized by a provision of the plan or trust instrument or if the investment is expressly authorized (or made) by a fiduciary of the plan (other than the bank or similar financial institution or any of its affiliates) who has authority to make such investments, or to instruct the trustee or other fiduciary with respect to investments, and who has no interest in the transaction which may affect the exercise of such authorizing fiduciary's best judgment as a fiduciary so as to cause such authorization to constitute an act described in section 406(b) of the Act. Any authorization to make investments contained in a plan or trust instrument will satisfy the requirement of express authorization for investments made prior to November 1, 1977. Effective November 1, 1977, in the case of a bank or similar financial institution that invests plan assets in deposits in itself or its affiliates under an authorization contained in a plan or trust instrument, such authorization must name such bank or similar financial institution and must state that such bank or similar financial institution may make investments in deposits which bear a reasonable rate of interest in itself (or in an affiliate).

(3) Example. B, a bank, is the trustee of plan P's assets. The trust instruments give the trustees the right to invest plan assets in its discretion. B invests in the certificates of deposit of bank C, which is a fiduciary of the plan by virtue of performing certain custodial and administrative services. The authorization is sufficient for the plan to make such investment under section 408(b)(4). Further, such authorization would suffice to allow B to make investments in deposits in itself prior to November 1, 1977. However, subsequent to October 31, 1977, B may not invest in deposits in itself, unless the plan or trust instrument specifically authorizes it to invest in deposits of B.

(c) Definitions. (1) The term bank or similar financial institution includes a bank (as defined in section 581 of the Code), a domestic building and loan association (as defined in section 7701(a)(19) of the Code), and a credit union (as defined in section 101(6) of the Federal Credit Union Act).

(2) A person is an affiliate of a bank or similar financial institution if such person and such bank or similar financial institution would be treated as members of the same controlled group of corporations or as members of two or more trades or businesses under common control within the meaning of section 414 (b) or (c) of the Code and the regulations thereunder.

(3) The term deposits includes any account, temporary or otherwise, upon which a reasonable rate of interest is paid, including a certificate of deposit issued by a bank or similar financial institution.

§ 2550.408b–6 Statutory exemption for ancillary services by a bank or similar financial institution.

(a) In general. Section 408(b)(6) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406 of the Act the provision of certain ancillary services by a bank or similar financial institution (as defined in §2550.408b–4(c)(1)) supervised by the United States or a State to a plan for which it acts as a fiduciary if the conditions of §2550.408b–6(b) are met. Such ancillary services include services which do not meet the requirements of section 408(b)(2) of the Act because the provision of such services involves an act described in section 406(b)(1) of the Act.

[42 FR 32392, June 24, 1977; 42 FR 36823, July 18, 1977]
§ 2550.408b–19  

(relating to fiduciaries dealing with the assets of plans in their own interest or for their own account) by the fiduciary bank or similar financial institution or an act described in section 406(b)(2) of the Act (relating to fiduciaries in their individual or in any other capacity acting in any transaction involving the plan on behalf of a party (or representing a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries). Section 408(b)(6) provides an exemption from sections 406(b)(1) and (2) because section 408(b)(6) contemplates the provision of such ancillary services without the approval of a second fiduciary (as described in §2550.408b–2(e)(2)) if the conditions of §2550.408b–6(b) are met. Thus, for example, plan assets held by a fiduciary bank which are reasonably expected to be needed to satisfy current plan expenses may be placed by the bank in a non-interest-bearing checking account in the bank if the conditions of §2550.408b–6(b) are met, notwithstanding the provisions of section 408(b)(4) of the Act (relating to investments in bank deposits). However, section 408(b)(6) does not provide an exemption for an act described in section 406(b)(3) of the Act (relating to fiduciaries receiving consideration for their own personal account from any party dealing with a plan in connection with a transaction involving the assets of the plan). The receipt of such consideration is a separate transaction not described in section 408(b)(6). Section 408(b)(6) does not contain an exemption from other provisions of the Act, such as section 404, or other provisions of law which may impose requirements or restrictions relating to the transactions which are exempt under section 408(b)(6) of the Act. See, for example, section 401 of the Internal Revenue Code of 1954. The provisions of section 408(b)(6) of the Act are further limited by section 408(a) of the Act (relating to transactions with owner-employees and related persons).

(b) Conditions. Such service must be provided—

(1) At not more than reasonable compensation;

(2) Under adequate internal safeguards which assure that the provision of such service is consistent with sound banking and financial practice, as determined by Federal or State supervisory authority; and

(3) Only to the extent that such service is subject to specific guidelines issued by the bank or similar financial institution which meet the requirements of §2550.408b–6(c).

[42 FR 32392, June 24, 1977; 42 FR 36823, July 18, 1977]

§ 2550.408b–19 Statutory exemption for cross-trading of securities.

(a) In general. (1) Section 408(b)(19) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406(a)(1)(A) and 406(b)(2) of the Act any cross-trade of securities if certain conditions are satisfied. Among other conditions, the exemption requires that the investment manager adopt, and effect cross-trades in accordance with, written cross-trading policies and procedures that are fair and equitable to all accounts participating in the cross-trading program, and that include:

(i) A description of the investment manager’s pricing policies and procedures; and

(ii) The investment manager’s policies and procedures for allocating cross-trades in an objective manner among accounts participating in the cross-trading program.

(2) Section 4975(d)(22) of the Internal Revenue Code of 1986 (the Code) contains parallel provisions to section 408(b)(19) of the Act. Effective December 31, 1978, section 102 of Reorganization Plan No. 4 of 1978, 5 U.S.C. App. 214 (2000 ed.), transferred the authority of the Secretary of the Treasury to promulgate regulations of the type published herein to the Secretary of Labor. Therefore, all references herein to section 408(b)(19) of the Act should be read to include reference to the parallel provisions of section 4975(d)(22) of the Code.

(3) Section 408(b)(19)(D) of the Act requires that a plan fiduciary for each plan participating in the cross-trades receive in advance of any cross-trades disclosure regarding the conditions under which the cross-trades may take place, including the written policies and procedures described in section
408(b)(19)(H) of the Act. This disclosure must be in a document that is separate from any other agreement or disclosure involving the asset management relationship. For purposes of section 408(b)(19)(D) of the Act, the policies and procedures furnished to the authorizing fiduciary must conform with the requirements of this regulation.

(4) The standards set forth in this section apply solely for purposes of determining whether an investment manager’s written policies and procedures satisfy the content requirements of section 408(b)(19)(H) of the Act. Accordingly, such standards do not determine whether the investment manager satisfies the other requirements for relief under section 408(b)(19) of the Act.

(b)(1) Policies and procedures. In general. This paragraph specifies the content of the written policies and procedures required to be adopted by an investment manager and disclosed to the plan fiduciary prior to authorizing cross-trading in order for transactions to qualify for relief under section 408(b)(19) of the Act.

(2) Style and format. The content of the policies and procedures required by this paragraph must be clear and concise and written in a manner calculated to be understood by the plan fiduciary authorizing cross-trading. Although no specific format is required for the investment manager’s written policies and procedures, the information contained in the policies and procedures must be sufficiently detailed to facilitate a periodic review by the compliance officer of the cross-trades and a determination by such compliance officer that the cross-trades comply with the investment manager’s written cross-trading policies and procedures.

(3) Content (i). An investment manager’s policies and procedures must be fair and equitable to all accounts participating in its cross-trading program and reasonably designed to ensure compliance with the requirements of section 408(b)(19)(H) of the Act. Such policies and procedures must include:

(A) A statement of policy which describes the criteria that will be applied by the investment manager in determining that execution of a securities transaction as a cross-trade will be beneficial to both parties to the transaction;

(B) A description of how the investment manager will determine that cross-trades are effected at the independent “current market price” of the security (within the meaning of section 270.17a–7(b) of Title 17, Code of Federal Regulations and SEC no-action and interpretative letters thereunder) as required by section 408(b)(19)(B) of the Act, including the identity of sources used to establish such price;

(C) A description of the procedures for ensuring compliance with the $100,000,000 minimum asset size requirement of section 408(b)(19). A plan or master trust will satisfy the minimum asset size requirement as to a transaction if it satisfies the requirement upon its initial participation in the cross-trading program and on an annual basis thereafter;

(D) A statement that any investment manager participating in a cross-trading program will have conflicting loyalties and responsibilities to the parties involved in any cross-trade transaction and a description of how the investment manager will mitigate such conflicts;

(E) A requirement that the investment manager allocate cross-trades among accounts in an objective and equitable manner and a description of the allocation method(s) available to and used by the investment manager for assuring an objective allocation among accounts participating in the cross-trading program. If more than one allocation methodology may be used by the investment manager, a description of what circumstances will dictate the use of a particular methodology;

(F) Identification of the compliance officer responsible for periodically reviewing the investment manager’s compliance with section 408(b)(19)(H) of the Act and a statement of the compliance officer’s qualifications for this position;

(G) A statement that the cross-trading statutory exemption under section 408(b)(19) of the Act requires satisfaction of several objective conditions in addition to the requirements that the investment manager adopt and effect cross-trades in accordance with written

669
cross-trading policies and procedures; and

(H) A statement which specifically describes the scope of the annual review conducted by the compliance officer.

(ii) Nothing herein is intended to preclude an investment manager from including such other policies and procedures not required by this regulation as the investment manager may determine appropriate to comply with the requirements of section 408(b)(19).

(c) Definitions. For purposes of this section:

(1) The term “account” includes any single customer or pooled fund or account.

(2) The term “compliance officer” means an individual designated by the investment manager who is responsible for periodically reviewing the cross-trades made for the plan to ensure compliance with the investment manager’s written cross-trading policies and procedures and the requirements of section 408(b)(19)(H) of the Act.

(3) The term “plan fiduciary” means a person described in section 3(21)(A) of the Act (other than the investment manager engaging in the cross-trades or an affiliate) who has the authority to authorize a plan’s participation in an investment manager’s cross-trading program.

(4) The term “investment manager” means a person described in section 3(38) of the Act.

(5) The term “plan” means any employee benefit plan as described in section 3(3) of the Act to which Title I of the Act applies or any plan defined in section 4975(e)(1) of the Code.

(6) The term “cross-trade” means the purchase and sale of a security between a plan and any other account managed by the same investment manager.

§2550.408c–2 29 CFR Ch. XXV (7–1–15 Edition)

Compensation for services.

(a) In general. Section 408(b)(2) of the Employee Retirement Income Security Act of 1974 (the Act) refers to the payment of reasonable compensation by a plan to a party in interest for services rendered to the plan. Section 408(c)(2) of the Act and §§2550.408c–2(b)(1) through 2550.408c–2(b)(4) clarify what constitutes reasonable compensation for such services.

(b)(1) General rule. Generally, whether compensation is “reasonable” under sections 408(b)(2) and (c)(2) of the Act depends on the particular facts and circumstances of each case.

(2) Payments to certain fiduciaries. Under sections 408(b)(2) and 408(c)(2) of the Act, the term “reasonable compensation” does not include any compensation to a fiduciary who is already receiving full-time pay from an employer or association of employers (any of whose employees are participants in the plan) or from an employee organization (any of whose members are participants in the plan), except for the reimbursement of direct expenses properly and actually incurred and not otherwise reimbursed. The restrictions of this paragraph (b)(2) do not apply to a party in interest who is not a fiduciary.

(c) Definitions. For purposes of this section:

(1) The term “account” includes any single customer or pooled fund or account.

(2) The term “compliance officer” means an individual designated by the investment manager who is responsible for periodically reviewing the cross-trades made for the plan to ensure compliance with the investment manager’s written cross-trading policies and procedures and the requirements of section 408(b)(19)(H) of the Act.

(3) The term “plan fiduciary” means a person described in section 3(21)(A) of the Act (other than the investment manager engaging in the cross-trades or an affiliate) who has the authority to authorize a plan’s participation in an investment manager’s cross-trading program.

(4) The term “investment manager” means a person described in section 3(38) of the Act.

(5) The term “plan” means any employee benefit plan as described in section 3(3) of the Act to which Title I of the Act applies or any plan defined in section 4975(e)(1) of the Code.

(6) The term “cross-trade” means the purchase and sale of a security between a plan and any other account managed by the same investment manager.

[73 FR 58458, Oct. 7, 2008]
not be “reasonable compensation.” Depending upon the facts and circumstances of the particular situation, compensation which is not excessive under 26 CFR 1.162-7 may, nevertheless, not be “reasonable compensation” within the meaning of sections 408(b)(2) and 408(c)(2) of the Act.

§ 2550.408e Statutory exemption for acquisition or sale of qualifying employer securities and for acquisition, sale, or lease of qualifying employer real property.

(a) General. Section 408(e) of the Employee Retirement Income Security Act of 1974 (the Act) exempts from the prohibitions of section 406(a) and 406(b)(1) and (2) of the Act any acquisition or sale by a plan of qualifying employer securities (as defined in section 407(d)(5) of the Act), or any acquisition, sale or lease by a plan of qualifying employer real property (as defined in section 407(d)(4) of the Act) if certain conditions are met. The conditions are that:

(1) The acquisition, sale or lease must be for adequate consideration (which is defined in paragraph (d) of this section);
(2) No commission may be charged directly or indirectly to the plan with respect to the transaction; and
(3) In the case of an acquisition or lease of qualifying employer real property, or an acquisition of qualifying employer securities, by a plan other than an eligible individual account plan (as defined in section 407(d)(3) of the Act), the acquisition or lease must comply with the requirements of section 407(a) of the Act.

(b) Acquisition. For purposes of section 408(e) and this section, an acquisition by a plan of qualifying employer securities or qualifying employer real property shall include, but not be limited to, an acquisition by purchase, by the exchange of plan assets, by the exercise of warrants or rights, by the conversion of a security, by default of a loan where the qualifying employer security or qualifying employer real property was security for the loan, or in connection with the contribution of such securities or real property to the plan. However, an acquisition of a security shall not be deemed to have occurred if a plan acquires the security as a result of a stock dividend or stock split.

(c) Sale. For purposes of section 408(e) and this section, a sale of qualifying employer real property or qualifying employer securities shall include any disposition for value.

(d) Adequate consideration. For purposes of section 408(e) and this section, adequate consideration means:

(1) In the case of a marketable obligation, a price not less favorable to the plan than the price determined under section 407(e)(1) of the Act; and
(2) In all other cases, a price not less favorable to the plan than the price determined under section 3(18) of the Act.

§ 2550.408g–1 Investment advice—participants and beneficiaries.

(a) In general. (1) This section provides relief from the prohibitions of section 406 of the Employee Retirement Income Security Act of 1974, as amended (ERISA or the Act), and section 4975 of the Internal Revenue Code of 1986, as amended (the Code), for certain transactions in connection with the provision of investment advice to participants and beneficiaries. This section, at paragraph (b), implements the statutory exemption set forth at sections 408(b)(14) and 408(g)(1) of ERISA and sections 4975(d)(17) and 4975(f)(8) of the Code. The requirements and conditions set forth in this section apply solely for the relief described in paragraph (b) of this section and, accordingly, no inferences should be drawn with respect to requirements applicable to the provision of investment advice not addressed by this section.

(2) Nothing contained in ERISA section 408(g)(1), Code section 4975(f)(8), or
this regulation imposes an obligation on a plan fiduciary or any other party to offer, provide or otherwise make available any investment advice to a participant or beneficiary.

(3) Nothing contained in ERISA section 408(g)(1), Code section 4975(f)(8), or this regulation invalidates or otherwise affects prior regulations, exemptions, interpretive or other guidance issued by the Department of Labor pertaining to the provision of investment advice and the circumstances under which such advice may or may not constitute a prohibited transaction under section 406 of ERISA or section 4975 of the Code.

(b) Statutory exemption—(1) General. Sections 408(b)(14) and 408(g)(1) of ERISA provide an exemption from the prohibitions of section 406 of ERISA for transactions described in section 408(b)(14) of ERISA in connection with the provision of investment advice to a participant or a beneficiary if the investment advice is provided by a fiduciary adviser under an "eligible investment advice arrangement." Sections 4975(d)(17) and (f)(8) of the Code contain parallel provisions to ERISA sections 408(b)(14) and (g)(1).

(2) Eligible investment advice. For purposes of section 408(g)(1) of ERISA and section 4975(f)(8) of the Code, an "eligible investment advice arrangement" means an arrangement that meets either the requirements of paragraph (b)(3) of this section or paragraph (b)(4) of this section, or both.

(3) Arrangements that use fee leveling. For purposes of this section, an arrangement is an eligible investment advice arrangement if—

(i)(A) Any investment advice is based on generally accepted investment theories that take into account the historic risks and returns of different asset classes over defined periods of time, although nothing herein shall preclude any investment advice from being based on generally accepted investment theories that take into account additional considerations;

(B) Any investment advice takes into account investment management and other fees and expenses attendant to the recommended investments;

(C) Any investment advice takes into account, to the extent furnished by a plan, participant or beneficiary, information relating to age, time horizons (e.g., life expectancy, retirement age), risk tolerance, current investments in designated investment options, other assets or sources of income, and investment preferences of the participant or beneficiary. A fiduciary adviser shall request such information, but nothing in this paragraph (b)(3)(i)(C) shall require that any investment advice take into account information requested, but not furnished by a participant or beneficiary, nor preclude requesting and taking into account additional information that a plan or participant or beneficiary may provide;

(D) No fiduciary adviser (including any employee, agent, or registered representative) that provides investment advice receives from any party (including an affiliate of the fiduciary adviser), directly or indirectly, any fee or other compensation (including commissions, salary, bonuses, awards, promotions, or other things of value) that varies depending on the basis of a participant’s or beneficiary’s selection of a particular investment option; and

(ii) The requirements of paragraphs (b)(5), (6), (7), (8) and (9) and paragraph (d) of this section are met.

(4) Arrangements that use computer models. For purposes of this section, an arrangement is an eligible investment advice arrangement if the only investment advice provided under the arrangement is advice that is generated by a computer model described in paragraphs (b)(4)(i) and (ii) of this section under an investment advice program and with respect to which the requirements of paragraphs (b)(5), (6), (7), (8) and (9) and paragraph (d) of this section are met.

(i) A computer model shall be designed and operated to—

(A) Apply generally accepted investment theories that take into account the historic risks and returns of different asset classes over defined periods of time, although nothing herein shall preclude a computer model from applying generally accepted investment theories that take into account additional considerations;

(B) Take into account investment management and other fees and expenses attendant to the recommended investments;

(C) Any investment advice takes into account, to the extent furnished by a plan, participant or beneficiary, information relating to age, time horizons (e.g., life expectancy, retirement age), risk tolerance, current investments in designated investment options, other assets or sources of income, and investment preferences of the participant or beneficiary. A fiduciary adviser shall request such information, but nothing in this paragraph (b)(3)(i)(C) shall require that any investment advice take into account information requested, but not furnished by a participant or beneficiary, nor preclude requesting and taking into account additional information that a plan or participant or beneficiary may provide;

(D) No fiduciary adviser (including any employee, agent, or registered representative) that provides investment advice receives from any party (including an affiliate of the fiduciary adviser), directly or indirectly, any fee or other compensation (including commissions, salary, bonuses, awards, promotions, or other things of value) that varies depending on the basis of a participant’s or beneficiary’s selection of a particular investment option; and

(ii) The requirements of paragraphs (b)(5), (6), (7), (8) and (9) and paragraph (d) of this section are met.

(4) Arrangements that use computer models. For purposes of this section, an arrangement is an eligible investment advice arrangement if the only investment advice provided under the arrangement is advice that is generated by a computer model described in paragraphs (b)(4)(i) and (ii) of this section under an investment advice program and with respect to which the requirements of paragraphs (b)(5), (6), (7), (8) and (9) and paragraph (d) of this section are met.

(i) A computer model shall be designed and operated to—

(A) Apply generally accepted investment theories that take into account the historic risks and returns of different asset classes over defined periods of time, although nothing herein shall preclude a computer model from applying generally accepted investment theories that take into account additional considerations;

(B) Take into account investment management and other fees and expenses attendant to the recommended investments;
(C) Appropriately weight the factors used in estimating future returns of investment options;

(D) Request from a participant or beneficiary and, to the extent furnished, utilize information relating to age, time horizons (e.g., life expectancy, retirement age), risk tolerance, current investments in designated investment options, other assets or sources of income, and investment preferences; provided, however, that nothing herein shall preclude a computer model from requesting and taking into account additional information that a plan or a participant or beneficiary may provide;

(E) Utilize appropriate objective criteria to provide asset allocation portfolios comprised of investment options available under the plan;

(F) Avoid investment recommendations that:

(1) Inappropriately favor investment options offered by the fiduciary adviser or a person with a material affiliation or material contractual relationship with the fiduciary adviser over other investment options, if any, available under the plan; or

(2) Inappropriately favor investment options that may generate greater income for the fiduciary adviser or a person with a material affiliation or material contractual relationship with the fiduciary adviser; and

(G)(i) Except as provided in paragraph (b)(4)(i)(G)(2) of this section, take into account all designated investment options, within the meaning of paragraph (c)(1) of this section, available under the plan without giving inappropriate weight to any investment option.

(2) A computer model shall not be treated as failing to meet the requirements of this paragraph merely because it does not make recommendations relating to the acquisition, holding or sale of an investment option that:

(i) Constitutes an annuity option with respect to which a participant or beneficiary may allocate assets toward the purchase of a stream of retirement income payments guaranteed by an insurance company, provided that, contemporaneous with the provision of investment advice generated by the computer model, the participant or beneficiary is also furnished a general description of such options and how they operate; or

(ii) The participant or beneficiary requests to be excluded from consideration in such recommendations.

(ii) Prior to utilization of the computer model, the fiduciary adviser shall obtain a written certification, meeting the requirements of paragraph (b)(4)(iv) of this section, from an eligible investment expert, within the meaning of paragraph (b)(4)(iii) of this section, that the computer model meets the requirements of paragraph (b)(4)(i) of this section. If, following certification, a computer model is modified in a manner that may affect its ability to meet the requirements of paragraph (b)(4)(i), the fiduciary adviser shall, prior to utilization of the modified model, obtain a new certification from an eligible investment expert that the computer model, as modified, meets the requirements of paragraph (b)(4)(i).

(iii) The term “eligible investment expert” means a person that, through employees or otherwise, has the appropriate technical training or experience and proficiency to analyze, determine and certify, in a manner consistent with paragraph (b)(4)(iv) of this section, whether a computer model meets the requirements of paragraph (b)(4)(i).

(iv) A certification by an eligible investment expert shall—

(A) Be in writing;

(B) Contain—

(I) An identification of the methodology or methodologies applied in determining whether the computer model meets the requirements of paragraph (b)(4)(i) of this section;
§2550.408g–1

(2) An explanation of how the applied methodology or methodologies demonstrated that the computer model met the requirements of paragraph (b)(4)(i) of this section;

(3) A description of any limitations that were imposed by any person on the eligible investment expert’s selection or application of methodologies for determining whether the computer model meets the requirements of paragraph (b)(4)(i) of this section;

(4) A representation that the methodology or methodologies were applied by a person or persons with the educational background, technical training or experience necessary to analyze and determine whether the computer model meets the requirements of paragraph (b)(4)(i); and

(5) A statement certifying that the eligible investment expert has determined that the computer model meets the requirements of paragraph (b)(4)(i) of this section;

(C) Be signed by the eligible investment expert.

(v) The selection of an eligible investment expert as required by this section is a fiduciary act governed by section 404(a)(1) of ERISA.

(5) Arrangement must be authorized by a plan fiduciary. (i) Except as provided in paragraph (b)(5)(ii) of this section, the arrangement pursuant to which investment advice is provided to participants and beneficiaries pursuant to this section must be expressly authorized by a plan fiduciary (or, in the case of an Individual Retirement Account (IRA), the IRA beneficiary) other than: The person offering the arrangement; any person providing designated investment options under the plan; or any affiliate of either. Provided, however, that for purposes of the preceding, in the case of an IRA, an IRA beneficiary will not be treated as an affiliate of a person solely by reason of being an employee of such person.

(ii) In the case of an arrangement pursuant to which investment advice is provided to participants and beneficiaries of a plan sponsored by the person offering the arrangement or a plan sponsored by an affiliate of such person, the authorization described in paragraph (b)(5)(i) of this section may be provided by the plan sponsor of such plan, provided that the person or affiliate offers the same arrangement to participants and beneficiaries of unaffiliated plans in the ordinary course of its business.

(iii) For purposes of the authorization described in paragraph (b)(5)(i) of this section, a plan sponsor shall not be treated as a person providing a designated investment option under the plan merely because one of the designated investment options of the plan is an option that permits investment in securities of the plan sponsor or an affiliate.

(6) Annual audit. (i) The fiduciary adviser shall, at least annually, engage an independent auditor, who has appropriate technical training or experience and proficiency, and so represents in writing to the fiduciary adviser, to:

(A) Conduct an audit of the investment advice arrangements for compliance with the requirements of this section; and

(B) Within 60 days following completion of the audit, issue a written report to the fiduciary adviser and, except with respect to an arrangement with an IRA, to each fiduciary who authorized the use of the investment advice arrangement, in accordance with paragraph (b)(5) of this section, that—

(1) Identifies the fiduciary adviser,

(2) Indicates the type of arrangement (i.e., fee leveling, computer models, or both),

(3) If the arrangement uses computer models, or both computer models and fee leveling, indicates the date of the most recent computer model certification, and identifies the eligible investment expert that provided the certification, and

(4) Sets forth the specific findings of the auditor regarding compliance of the arrangement with the requirements of this section.

(ii) With respect to an arrangement with an IRA, the fiduciary adviser:

(A) Within 30 days following receipt of the report from the auditor, as described in paragraph (b)(6)(i)(B) of this section, shall furnish a copy of the report to the IRA beneficiary or make such report available on its Web site, provided that such beneficiaries are
provided information, with the information required to be disclosed pursuant to paragraph (b)(7) of this section, concerning the purpose of the report, and how and where to locate the report applicable to their account; and

(B) In the event that the report of the auditor identifies noncompliance with the requirements of this section, within 30 days following receipt of the report from the auditor, shall send a copy of the report to the Department of Labor at the following address: Investment Advice Exemption Notification, U.S. Department of Labor, Employee Benefits Security Administration, Room N–1513, 200 Constitution Ave., NW., Washington, DC 20210, or submit a copy electronically to InvAdvNotification@dol.gov.

(iii) For purposes of this paragraph (b)(6), an auditor is considered independent if it does not have a material affiliation or material contractual relationship with the person offering the investment advice arrangement to the plan or with any designated investment options under the plan, and does not have any role in the development of the investment advice arrangement, or certification of the computer model utilized under the arrangement.

(iv) For purposes of this paragraph (b)(6), the auditor shall review sufficient relevant information to formulate an opinion as to whether the investment advice arrangements, and the advice provided pursuant thereto, offered by the fiduciary adviser during the audit period were in compliance with this section. Nothing in this paragraph shall preclude an auditor from using information obtained by sampling, as reasonably determined appropriate by the auditor, investment advice arrangements, and the advice pursuant thereto, during the audit period.

(v) The selection of an auditor for purposes of this paragraph (b)(6) is a fiduciary act governed by section 404(a)(1) of ERISA.

(7) Disclosure to participants. (i) The fiduciary adviser must provide, without charge, to a participant or a beneficiary before the initial provision of investment advice with regard to any security or other property offered as an investment option, a written notification of:

(A) The role of any party that has a material affiliation or material contractual relationship with the fiduciary adviser in the development of the investment advice program, and in the selection of investment options available under the plan;

(B) The past performance and historical rates of return of the designated investment options available under the plan, to the extent that such information is not otherwise provided;

(C) All fees or other compensation that the fiduciary adviser or any affiliate thereof is to receive (including compensation provided by any third party) in connection with—

(1) The provision of the advice;

(2) The sale, acquisition, or holding of any security or other property pursuant to such advice; or

(3) Any rollover or other distribution of plan assets or the investment of distributed assets in any security or other property pursuant to such advice;

(D) Any material affiliation or material contractual relationship of the fiduciary adviser or affiliates thereof in the security or other property;

(E) The manner, and under what circumstances, any participant or beneficiary information provided under the arrangement will be used or disclosed;

(F) The types of services provided by the fiduciary adviser in connection with the provision of investment advice by the fiduciary adviser;

(G) The adviser is acting as a fiduciary of the plan in connection with the provision of the advice; and

(H) That a recipient of the advice may separately arrange for the provision of advice by another adviser that could have no material affiliation with and receive no fees or other compensation in connection with the security or other property.

(ii)(A) The notification required under paragraph (b)(7)(i) of this section must be written in a clear and conspicuous manner and in a manner calculated to be understood by the average plan participant and must be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of the information required to be provided in the notification.
(B) The appendix to this section contains a model disclosure form that may be used to provide notification of the information described in paragraph (b)(7)(i)(C) of this section. Use of the model form is not mandatory. However, use of an appropriately completed model disclosure form will be deemed to satisfy the requirements of paragraphs (b)(7)(i) and (ii) of this section with respect to such information.

(ii) The notification required under paragraph (b)(7)(i) of this section may, in accordance with 29 CFR 2520.104b–1, be provided in written or electronic form.

(iv) With respect to the information required to be disclosed pursuant to paragraph (b)(7)(i) of this section, the fiduciary adviser shall, at all times during the provision of advisory services to the participant or beneficiary pursuant to the arrangement—

(A) Maintain accurate, up-to-date information in a form that is consistent with paragraph (b)(7)(ii) of this section,

(B) Provide, without charge, accurate, up-to-date information to the recipient of the advice no less frequently than annually,

(C) Provide, without charge, accurate information to the recipient of the advice upon request of the recipient, and

(D) Provide, without charge, accurate information to the recipient of the advice any material change to the information described in paragraph (b)(7)(i) of this section at a time reasonably contemporaneous to the change in information.

(8) Disclosure to authorizing fiduciary. The fiduciary adviser shall, in connection with any authorization described in paragraph (b)(5)(i) of this section, provide the authorizing fiduciary with a written notice informing the fiduciary that:

(i) The fiduciary adviser intends to comply with the conditions of the statutory exemption for investment advice under section 408(b)(14) and (g) of the Employee Retirement Income Security Act and this section;

(ii) The fiduciary adviser’s arrangement will be audited annually by an independent auditor for compliance with the requirements of the statutory exemption and related regulations; and

(iii) The auditor will furnish the authorizing fiduciary a copy of that auditor’s findings within 60 days of its completion of the audit.

(9) Other conditions. The requirements of this paragraph are met if—

(i) The fiduciary adviser provides appropriate disclosure, in connection with the sale, acquisition, or holding of the security or other property, in accordance with all applicable securities laws.

(ii) Any sale, acquisition, or holding of a security or other property occurs solely at the direction of the recipient of the advice.

(iii) The compensation received by the fiduciary adviser and affiliates thereof in connection with the sale, acquisition, or holding of the security or other property is reasonable, and

(iv) The terms of the sale, acquisition, or holding of the security or other property are at least as favorable to the plan as an arm’s length transaction would be.

(c) Definitions. For purposes of this section:

(1) The term “designated investment option” means any investment option designated by the plan into which participants and beneficiaries may direct the investment of assets held in, or contributed to, their individual accounts. The term “designated investment option” shall not include “brokerage windows,” “self-directed brokerage accounts,” or similar plan arrangements that enable participants and beneficiaries to select investments beyond those designated by the plan. The term “designated investment alternative” has the same meaning as the term “designated investment alternative” as defined in 29 CFR 2550.404a–5(h).

(2)(i) The term “fiduciary adviser” means, with respect to a plan, a person who is a fiduciary of the plan by reason of the provision of investment advice referred to in section 3(21)(A)(ii) of ERISA by the person to the participant or beneficiary of the plan and who is—

(A) Registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1 et seq.) or under the laws of the State in which the fiduciary maintains its principal office and place of business.

(B) A bank or similar financial institution referred to in section 408(b)(4) of
ERISA or a savings association (as defined in section 3(b)(1) of the Federal Deposit Insurance Act (12 U.S.C. 1813(b)(1)), but only if the advice is provided through a trust department of the bank or similar financial institution or savings association which is subject to periodic examination and review by Federal or State banking authorities,

(C) An insurance company qualified to do business under the laws of a State,

(D) A person registered as a broker or dealer under the Securities Exchange Act of 1934 (15 U.S.C. 78a et seq.),

(E) An affiliate of a person described in paragraphs (c)(2)(i)(A) through (D), or

(F) An employee, agent, or registered representative of a person described in paragraphs (c)(2)(i)(A) through (E) of this section who satisfies the requirements of applicable insurance, banking, and securities laws relating to the provision of advice.

(ii) Except as provided under 29 CFR 2550.408g–2, a fiduciary adviser includes any person who develops the computer model, or markets the computer model or investment advice program, utilized in satisfaction of paragraph (b)(4) of this section.

(3) A “registered representative” of another entity means a person described in section 3(a)(18) of the Securities Exchange Act of 1934 (15 U.S.C. 78c(a)(18)) (substituting the entity for the broker or dealer referred to in such section) or a person described in section 202(a)(17) of the Investment Advisers Act of 1940 (15 U.S.C. 80b–2(a)(17)) (substituting the entity for the investment adviser referred to in such section).

(i) “Individual Retirement Account” or “IRA” means—

(A) An individual retirement account described in section 408(a) of the Code;

(B) An individual retirement annuity described in section 408(b) of the Code;

(C) An Archer MSA described in section 220(d) of the Code;

(D) A health savings account described in section 223(d) of the Code;

(E) A Coverdell education savings account described in section 530 of the Code;

(F) A trust, plan, account, or annuity which, at any time, has been determined by the Secretary of the Treasury to be described in any of paragraphs (c)(4)(i) through (v) of this section;

(vii) A “simplified employee pension” described in section 408(k) of the Code; or

(viii) A “simple retirement account” described in section 408(p) of the Code.

(5) An “affiliate” of another person means—

(i) Any person directly or indirectly owning, controlling, or holding with power to vote, 5 percent or more of the outstanding voting securities of such other person;

(ii) Any person 5 percent or more of whose outstanding voting securities are directly or indirectly owned, controlled, or held with power to vote, by such other person;

(iii) Any person directly or indirectly controlling, controlled by, or under common control with, such other person; and

(iv) Any officer, director, partner, copartner, or employee of such other person.

(6)(i) A person with a “material affiliation” with another person means—

(A) Any affiliate of the other person;

(B) Any person directly or indirectly owning, controlling, or holding, 5 percent or more of the interests of such other person; and

(C) Any person 5 percent or more of whose interests are directly or indirectly owned, controlled, or held, by such other person.

(ii) For purposes of paragraph (c)(6)(i) of this section, “interest” means with respect to an entity—

(A) The combined voting power of all classes of stock entitled to vote or the total value of the shares of all classes of stock of the entity if the entity is a corporation;

(B) The capital interest or the profits interest of the entity if the entity is a partnership; or

(C) The beneficial interest of the entity if the entity is a trust or unincorporated enterprise.

(7) Persons have a “material contractual relationship” if payments made by one person to the other person pursuant to contracts or agreements between the persons exceed 10 percent of the gross revenue, on an annual basis, of such other person.
§ 2550.408g–1

(8) “Control” means the power to exercise a controlling influence over the management or policies of a person other than an individual.

(d) Retention of records. The fiduciary adviser must maintain, for a period of not less than 6 years after the provision of investment advice under this section any records necessary for determining whether the applicable requirements of this section have been met. A transaction prohibited under section 406 of ERISA shall not be considered to have occurred solely because the records are lost or destroyed prior to the end of the 6-year period due to circumstances beyond the control of the fiduciary adviser.

(e) Noncompliance. (1) The relief from the prohibited transaction provisions of section 406 of ERISA and the sanctions resulting from the application of section 4975 of the Code described in paragraph (b) of this section shall not apply to any transaction described in such paragraphs in connection with the provision of investment advice to an individual participant or beneficiary with respect to which the applicable conditions of this section have not been satisfied.

(2) In the case of a pattern or practice of noncompliance with any of the applicable conditions of this section, the relief described in paragraph (b) of this section shall not apply to any transaction in connection with the provision of investment advice provided by the fiduciary adviser during the period over which the pattern or practice extended.

(f) Effective date and applicability date. This section shall be effective December 27, 2011. This section shall apply to transactions described in paragraph (b) of this section occurring on or after December 27, 2011.

APPENDIX TO § 2550.408g–1

FIDUCIARY ADVISER DISCLOSURE

This document contains important information about [enter name of Fiduciary Adviser] and how it is compensated for the investment advice provided to you. You should carefully consider this information in your evaluation of that advice.

[enter name of Fiduciary Adviser] has been selected to provide investment advisory services for the [enter name of Plan]. [enter name of Fiduciary Adviser] will be providing these services as a fiduciary under the Employee Retirement Income Security Act (ERISA). [enter name of Fiduciary Adviser], therefore, must act prudently and with only your interest in mind when providing you recommendations on how to invest your retirement assets.

COMPENSATION OF THE FIDUCIARY ADVISER AND RELATED PARTIES

[enter name of Fiduciary Adviser] (is/is not) compensated by the plan for the advice it provides. (If compensated by the plan, explain what and how compensation is charged (e.g., asset-based fee, flat fee, per advice)). (If applicable, [enter name of Fiduciary Adviser] is not compensated on the basis of the investment(s) selected by you.)

Affiliates of [enter name of Fiduciary Adviser] (if applicable enter, and other parties with whom [enter name of Fiduciary Adviser] is related or has a material financial relationship) also will be providing services for which they will be compensated. These services include: [enter description of services, e.g., investment management, transfer agent, custodial, and shareholder services for some/all the investment funds available under the plan.]

When [enter name of Fiduciary Adviser] recommends that you invest your assets in an investment fund of its own or one of its affiliates and you follow that advice, [enter name of Fiduciary Adviser] or that affiliate will receive compensation from the investment fund based on the amount you invest. The amounts that will be paid by you will vary depending on the particular fund in which you invest your assets and may range from _% to _%. Specific information concerning the fees and other charges of each investment fund is available from [enter source, such as: your plan administrator, investment fund provider (possibly with Internet Web site address)]. This information should be reviewed carefully before you make an investment decision.

(If applicable enter, [enter name of Fiduciary Adviser] or affiliates of [enter name of Fiduciary Adviser] also receive compensation from non-affiliated investment funds as a result of investments you make as a result of recommendations of [enter name of Fiduciary Adviser]). The amount of this compensation may range from _% to _%. Specific information concerning the fees and other charges of each investment fund is available from [enter source, such as: your plan administrator, investment fund provider (possibly with Internet Web site address)]. This information should be reviewed carefully before you make an investment decision.

(If applicable enter, In addition to the above, [enter name of Fiduciary Adviser] or affiliates of [enter name of Fiduciary Adviser] also receive other fees or compensation, such
as commissions, in connection with the sale, acquisition or holding of investments selected by you as a result of recommendations of [enter name of Fiduciary Adviser]. These amounts are: [enter description of all other fees or compensation to be received in connection with sale, acquisition or holding of investments]. This information should be reviewed carefully before you make an investment decision.

(if applicable) When [enter name of Fiduciary Adviser] recommends that you take a rollover or other distribution of assets from the plan, or recommends how those assets should subsequently be invested, [enter name of Fiduciary Adviser] or affiliates of [enter name of Fiduciary Adviser] will receive additional fees or compensation. These amounts are: [enter description of all other fees or compensation to be received in connection with any rollover or other distribution of plan assets or the investment of distributed assets]. This information should be reviewed carefully before you make a decision to take a distribution.

CONSIDER IMPACT OF COMPENSATION ON ADVICE

The fees and other compensation that [enter name of Fiduciary Adviser] and its affiliates receive on account of assets in [enter name of Fiduciary Adviser] (enter if applicable) and non-[enter name of Fiduciary Adviser]) investment funds are a significant source of revenue for the [enter name of Fiduciary Adviser] and its affiliates. You should carefully consider the impact of any such fees and compensation in your evaluation of the investment advice that [enter name of Fiduciary Adviser] provides to you. In this regard, you may arrange for the provision of advice by another adviser that may have no material affiliation with or receive no compensation in connection with the investment funds or products offered under the plan. This type of advice is/is not available through your plan.

INVESTMENT RETURNS

While understanding investment-related fees and expenses is important in making informed investment decisions, it is also important to consider additional information about your investment options, such as performance, investment strategies and risks. Specific information related to the past performance and historical rates of return of the investment options available under the plan (has/has not) been provided to you by [enter source, such as: your plan administrator, investment fund provider]. (If applicable enter, if not provided to you, the information is attached to this document.)

For options with returns that vary over time, past performance does not guarantee how your investment in the option will perform in the future; your investment in these options could lose money.

PARTIES PARTICIPATING IN DEVELOPMENT OF ADVICE PROGRAM OR SELECTION OF INVESTMENT OPTIONS

Name, and describe role of, affiliates or other parties with whom the fiduciary adviser has a material affiliation or contractual relationship that participated in the development of the investment advice program (if this is an arrangement that uses computer models) or the selection of investment options available under the plan.

USE OF PERSONAL INFORMATION

Include a brief explanation of the following—What personal information will be collected; How the information will be used; Parties with whom information will be shared; How the information will be protected; and When and how notice of the Fiduciary Adviser’s privacy statement will be available to participants and beneficiaries.

Should you have any questions about [enter name of Fiduciary Adviser] or the information contained in this document, you may contact [enter name of contact person for fiduciary adviser, telephone number, address].

(76 FR 66162, Oct. 25, 2011)

§ 2550.408g–2 Investment advice—fiduciary election.

(a) General. Section 408(g)(11)(A) of the Employee Retirement Income Security Act, as amended (ERISA), provides that a person who develops a computer model or who markets a computer model or investment advice program used in an “eligible investment advice arrangement” shall be treated as a fiduciary of a plan by reason of the provision of investment advice referred to in ERISA section 3(21)(A)(11) to the plan participant or beneficiary, and shall be treated as a “fiduciary adviser” for purposes of ERISA sections 408(b)(14) and 408(g), except that the Secretary of Labor may prescribe rules under which only one fiduciary adviser may elect to be treated as a fiduciary with respect to the plan.

Section 4975(f)(J) of the Internal Revenue Code, as amended (the Code), contains a parallel provision to ERISA section 408(g)(11)(A) that applies for purposes of Code sections 4975(d)(17) and 4975(f)(8). This section sets forth requirements that must be satisfied in order for one such fiduciary adviser to elect to be treated as a fiduciary with
§ 2550.412–1 Temporary bonding requirements.

(a) Pending the issuance of permanent regulations with respect to the bonding provisions under section 412 of the Employee Retirement Income Security Act of 1974 (the Act), any plan official, as defined in section 412(a) of the Act, shall be deemed to be in compliance with the bonding requirements of the Act if he or she is bonded under a bond which would have been in compliance with section 13 of the Welfare and Pension Plans Disclosure Act, as amended (the WPPDA), and with the basic bonding requirements of subparts A through E of part 2580, title 29 CFR, and with the prohibition against bonding by parties interested in the plan contained in subpart G of part 2580 of such title, or would be exempt from such bonding requirements because bonding would not be required under the exemption provisions contained in subpart F of part 2580 of such title. Part 2580 of this title incorporates material previously designated as subparts A through E of part 464, subpart B of part 465 and part 485 of this title of the CFR. The requirements which are set forth in the temporary regulations hereby adopted shall be applicable to all employee benefit plans covered by the Act, including those plans which were not covered by the WPPDA. Thus, for example, the regulations so adopted are applicable to plans containing fewer than 26 participants, although such plans were not covered by the WPPDA.

(b) For the purpose of this temporary regulation, any bond or rider thereto obtained by a plan official which contains a reference to the WPPDA will be construed by the Secretary to refer to the Act: Provided, That the surety company so agrees.

(c) For the purpose of this regulation,

(1) Any reference to section 13 of the WPPDA or any subsection thereof in the regulations issued under the WPPDA and which are incorporated by reference by this temporary regulation shall be deemed to refer to section 412 of the Act, or the corresponding subsection thereof.

(2) Where the particular phrases set forth in the Act are not identical to the phrases in the WPPDA and the regulations issued pursuant thereto, the phrases appearing in the Act shall be substituted by operation of law, and

(3) Where the phrases are identical but the meaning is different, the meaning given such phrases by the Act shall govern. For example, the phrase “administrators, officers, and employees of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handle funds or other property of such plan” which appears in section 13 of the WPPDA and the regulations issued thereunder shall be construed to mean, for purposes of this regulation, “plan officials”, which...
is the term appearing in section 412 of
the Act, and the terms “employee wel-
fare benefit plan” and “employee pen-
sion benefit plan” shall be given the
meaning assigned to them by the Act,
and not the meaning set forth in the
WPPDA.
(d) The requirements of this tem-
porary regulation, as set forth in para-
graphs (a) through (c) of this section,
shall remain in effect pending the
issuance of permanent regulations by
the Secretary.

[40 FR 2203, Jan. 10, 1975. Redesignated at 40
FR 20629, May 12, 1975, as amended at 50 FR
26706, June 28, 1985]
Sec. 2560.502–1 Requests for enforcement pursuant to section 502(b)(2).

2560.502c–2 Civil penalties under section 502(c)(2).

2560.502c–4 Civil penalties under section 502(c)(4).

2560.502c–5 Civil penalties under section 502(c)(5).

2560.502c–6 Civil penalties under section 502(c)(6).

2560.502c–7 Civil penalties under section 502(c)(7).

2560.502c–8 Civil penalties under section 502(c)(8).

2560.502i–1 Civil penalties under section 502(i).

2560.521–1 Cease and desist and seizure orders under section 521.

2560.521–2 Disclosure of order and proceedings.

2560.521–3 Effect on other enforcement authority.

2560.521–4 Cross-reference.


§ 2560.502–1 Requests for enforcement pursuant to section 502(b)(2).

(a) Form, content and filing. All requests by participants, beneficiaries, and fiduciaries for the Secretary of Labor to exercise his enforcement authority pursuant to section 502(a)(5), 29 U.S.C. 1132(a)(5), with respect to a violation of, or the enforcement of, parts 2 and 3 of title I of the Employee Retirement Income Security Act of 1974 (the Act) shall be in writing and shall contain information sufficient to form a basis for identifying the participant, beneficiary, or fiduciary and the plan involved. All such requests shall be considered filed if they are directed to and received by any office or official of the Department of Labor or referred to and received by any such office or official by any party to whom such writing is directed.

(b) Consideration. The Secretary of Labor retains discretion to determine whether any enforcement proceeding should be commenced in the case of any request received pursuant to paragraph (a) of this section, and he may, but shall not be required to, exercise his authority pursuant to section 502(a)(5) of the Act only if he determines that such violation affects, or such enforcement is necessary to protect claims of participants or beneficiaries to benefits under the plan.

43 FR 50175, Oct. 27, 1978

§ 2560.502c–2 Civil penalties under section 502(c)(2).

(a) In general. (1) Pursuant to the authority granted the Secretary under section 502(c)(2) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator (within the meaning of section 3(16)(A)) of an employee benefit plan (within the meaning of section 3(3) and §2510.3–1, et seq.) for which an annual report is required to be filed under section 101(b)(1) shall be liable for civil penalties assessed by the Secretary under section 502(c)(2) of the Act in each case in which there is a failure or refusal to file the annual report required to be filed under section 101(b)(1).
maximum amount as may be established by regulation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended), computed from the date of the administrator’s failure or refusal to file the annual report and, except as provided in paragraph (b)(2) of this section, continuing up to the date on which an annual report satisfactory to the Secretary is filed.

(2) If upon receipt of a notice of intent to assess a penalty (as described in paragraph (c) of this section) the administrator files a statement of reasonable cause for the failure to file, in accordance with paragraph (e) of this section, a penalty shall not be assessed for any day from the date the Department serves the administrator with a copy of such notice until the day after the Department serves notice on the administrator of its determination on reasonable cause and its intention to assess a penalty (as described in paragraph (g) of this section).

(3) For purposes of this paragraph, the date on which the administrator failed or refused to file the annual report shall be the date on which the annual report was due (determined without regard to any extension for filing). An annual report which is rejected under section 104(a)(4) for a failure to provide material information shall be treated as a failure to file an annual report when a revised report satisfactory to the Department is not filed within 45 days of the date of the Department’s notice of rejection.

A penalty shall not be assessed under section 502(c)(2) for any day earlier than the day after the date of an administrator’s failure or refusal to file the annual report if a revised filing satisfactory to the Department is not submitted within 45 days of the date of the notice of rejection by the Department.

(c) Notice of intent to assess a penalty. Prior to the assessment of any penalty under section 502(c)(2), the Department shall provide to the administrator of the plan a written notice indicating the Department’s intent to assess a penalty under section 502(c)(2), the amount of such penalty, the period to which the penalty applies, and the reason(s) for the penalty.

(d) Reconsideration or waiver of penalty to be assessed. The Department may determine that all or part of the penalty amount in the notice of intent to assess a penalty shall not be assessed on a showing that the administrator complied with the requirements of section 101(b)(1) of the Act or on a showing by the administrator of mitigating circumstances regarding the degree or willfulness of the noncompliance.

(e) Showing of reasonable cause. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have thirty (30) days from the date of service of the notice, as described in paragraph (i) of this section, to file a statement of reasonable cause explaining why the penalty, as calculated, should be reduced, or not be assessed, for the reasons set forth in paragraph (d) of this section. Such statement must be made in writing and set forth all the facts alleged as reasonable cause for the reduction or nonassessment of the penalty. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) Failure to file a statement of reasonable cause. Failure of an administrator to file a statement of reasonable cause within the thirty (30) day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice of intent, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(2) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of §2070.61(g) of this chapter, forty-five (45) days from the date of service of the notice.

(g) Notice of the determination on statement of reasonable cause. (1) The Department, following a review of all the facts alleged in support of no assessment or a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its determination to waive the penalty, in whole or in part, and/or assess a penalty. If it is the determination of the Department to assess a penalty, the notice shall indicate the amount of the penalty, not
to exceed the amount described in paragraph (c) of this section. This notice is a “pleading” for purposes of §2570.61(m) of this chapter.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) of this section, indicating the Department’s intention to assess a penalty, shall become a final order, within the meaning of §2570.61(g) of this chapter, forty-five (45) days from the date of service of the notice.

(h) Administrative hearing. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of §2570.61(g) of this chapter, if, within thirty (30) days from the date of the service of the notice, the administrator or a representative thereof files a request for a hearing under §§2570.60 through 2570.71 of this chapter, and files an answer to the notice. The request for hearing and answer must be filed in accordance with §2570.62 of this chapter and §18.4 of this title. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) Service of notices and filing of statements. (1) Service of a notice for purposes of paragraphs (c) and (g) of this section shall be made:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is by regular mail, service is complete upon receipt by the addressee. When service of a notice under paragraph (c) or (g) of this section is by certified mail, five (5) days shall be added to the time allowed by these rules for the filing of a statement, or a request for hearing and answer, as applicable.

(3) For purposes of this section, a statement of reasonable cause shall be considered filed:

(i) Upon mailing, if accomplished using United States Postal Service certified mail or Express Mail;

(ii) Upon receipt by the delivery service, if accomplished using a “designated private delivery service” within the meaning of 26 U.S.C. 7502(f);

(iii) Upon transmittal, if transmitted in a manner specified in the notice of intent to assess a penalty as a method of transmittal to be accorded such special treatment; or

(iv) In the case of any other method of filing, upon receipt by the Department at the address provided in the notice of intent to assess a penalty.

(j) Liability. (1) If more than one person is responsible as administrator for the failure to file the annual report, all such persons shall be jointly and severally liable with respect to such failure.

(2) Any person against whom a civil penalty has been assessed under section 502(c)(2) pursuant to a final order, within the meaning of §2570.61(g), shall be personally liable for the payment of such penalty.

(k) Cross-reference. See §§2570.60 through 2570.71 of this chapter for procedural rules relating to administrative hearings under section 502(c)(2) of the Act.


§ 2560.502c–4 Civil penalties under section 502(c)(4).

(a) In general. (1) Pursuant to the authority granted the Secretary under section 502(c)(4) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator (within the meaning of section 3(16)(A) of the Act) shall be liable for civil penalties assessed by the Secretary under section 502(c)(4) of the Act, for failure or refusal to furnish:

(i) Notice of funding-based limits in accordance with section 101(j) of the Act;

(ii) Actuarial, financial or funding information in accordance with section 101(k) of the Act;

(iii) Notice of potential withdrawal liability in accordance with section 101(l) of the Act; or
(iv) Notice of rights and obligations under an automatic contribution arrangement in accordance with section 514(e)(3) of the Act.

(2) For purposes of this section, a failure or refusal to furnish the items referred to in paragraph (a)(1) above shall mean a failure or refusal to furnish, in whole or in part, the items required under section 101(j), (k), or (l), or section 514(e)(3) of the Act at the relevant times and manners prescribed in such sections.

(b) Amount assessed. (1) The amount assessed under section 502(c)(4) of the Act for each separate violation shall be determined by the Department of Labor, taking into consideration the degree or willfulness of the failure or refusal to furnish the items referred to in paragraph (a) of this section. However, the amount assessed for each violation under section 502(c)(4) of the Act shall not exceed $1,000 a day (or such other maximum amount as may be established by regulation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended), computed from the date of the administrator’s failure or refusal to furnish the items referred to in paragraph (a) of this section.

(2) For purposes of calculating the amount to be assessed under this section, a failure or refusal to furnish the item with respect to any person entitled to receive such item, shall be treated as a separate violation under section 101(j), (k), or (l), or section 514(e)(3) of the Act, as applicable.

(c) Notice of intent to assess a penalty. Prior to the assessment of any penalty under section 502(c)(4) of the Act, the Department shall provide to the administrator of the plan a written notice indicating the Department’s intent to assess a penalty under section 502(c)(4) of the Act, the amount of such penalty, the number of individuals on which the penalty is based, the period to which the penalty applies, and the reason(s) for the penalty.

(d) Reconsideration or waiver of penalty to be assessed. The Department may determine that all or part of the penalty amount in the notice of intent to assess a penalty shall not be assessed on a showing that the administrator complied with the requirements of section 101(j), (k), or (l), or section 514(e)(3) of the Act, as applicable, or on a showing by such person of mitigating circumstances regarding the degree or willfulness of the noncompliance.

(e) Showing of reasonable cause. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have thirty (30) days from the date of service of the notice, as described in paragraph (i) of this section, to file a statement of reasonable cause explaining why the penalty, as calculated, should be reduced, or not be assessed, for the reasons set forth in paragraph (d) of this section. Such statement must be made in writing and set forth all the facts alleged as reasonable cause for the reduction or non-assessment of the penalty. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) Failure to file a statement of reasonable cause. Failure to file a statement of reasonable cause within the thirty (30) day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice of intent, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(4) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of §2570.131(g) of this chapter, forty-five (45) days from the date of service of the notice.

(g) Notice of determination on statement of reasonable cause. (1) The Department, following a review of all of the facts in a statement of reasonable cause alleged in support of nonassessment or a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its determination on the statement of reasonable cause and its determination whether to waive the penalty in whole or in part, and/or assess a penalty. If it is the determination of the Department to assess a penalty, the notice shall indicate the amount of the penalty assessment, not to exceed the amount described in
(c) of this section. This notice is a "pleading" for purposes of §2570.131(m) of this chapter.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) of this section, indicating the Department's determination to assess a penalty, shall become a final order, within the meaning of §2570.131(g) of this chapter, forty-five (45) days from the date of service of the notice.

(h) Administrative hearing. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of §2570.131(g) of this chapter, if, within thirty (30) days from the date of the service of the notice, the administrator or a representative thereof files a request for a hearing under §§ 2570.130 through 2570.141 of this chapter, and files an answer to the notice. The request for hearing and answer must be filed in accordance with §2570.132 of this chapter and §18.4 of this title. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) Service of notices and filing of statements. (1) Service of a notice for purposes of paragraphs (c) and (g) of this section shall be made:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is by regular mail, service is complete upon receipt by the addressee. When service of a notice under paragraph (c) or (g) of this section is by certified mail, five days shall be added to the time allowed by these rules for the filing of a statement or a request for hearing and answer, as applicable.

(3) For purposes of this section, a statement of reasonable cause shall be considered filed:

(i) Upon mailing, if accomplished using United States Postal Service certified mail or express mail;

(ii) Upon receipt by the delivery service, if accomplished using a "designated private delivery service" within the meaning of 26 U.S.C. 7502(c);

(iii) Upon transmittal, if transmitted in a manner specified in the notice of intent to assess a penalty as a method of transmittal to be accorded such special treatment; or

(iv) In the case of any other method of filing, upon receipt by the Department at the address provided in the notice of intent to assess a penalty.

(j) Liability. (1) If more than one person is responsible as administrator for the failure to furnish the items required under section 101(j), (k), or (l), or section 514(e)(3) of the Act, as applicable, all such persons shall be jointly and severally liable for such failure. For purposes of paragraph (a)(1)(iii) of this section, the term "administrator" shall include plan sponsor (within the meaning of section 3(16)(B) of the Act).

(2) Any person, or persons under paragraph (j)(1) of this section, against whom a civil penalty has been assessed under section 502(c)(4) of the Act, pursuant to a final order within the meaning of §2570.131(g) of this chapter shall be personally liable for the payment of such penalty.

(k) Cross-references. (1) The procedural rules in §§ 2570.130 through 2570.141 of this chapter apply to administrative hearings under section 502(c)(4) of the Act.

(2) When applying procedural rules in §§ 2570.130 through 2570.140:

(i) Wherever the term "502(c)(7)" appears, such term shall mean "502(c)(4)";

(ii) Reference to §2560.502c–7(g) in 2570.131(c) shall be construed as reference to §2560.502c–4(g) of this chapter;

(iii) Reference to §2560.502c–7(e) in §2570.131(g) shall be construed as reference to §2560.502c–4(e) of this chapter;

(iv) Reference to §2560.502c–7(g) in §2570.131(m) shall be construed as reference to §2560.502c–4(g); and

(v) Reference to §§ 2560.502c–7(g) and 2560.502c–7(h) in §2570.131 shall be construed as reference to §§ 2560.502c–4(g) and 2560.502c–4(h), respectively.
§ 2560.502c–5 Civil penalties under section 502(c)(5).

(a) In general—(1) Pursuant to the authority granted the Secretary under section 502(c)(5) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a multiple employer welfare arrangement (MEWA) (within the meaning of section 3(40)(A) of the Act) that is not a group health plan, and that provides benefits consisting of medical care (within the meaning of section 733(a)(2)), for which a report is required to be filed under section 101(g) and 29 CFR 2520.101–2, shall be liable for civil penalties assessed by the Secretary under section 502(c)(5) of the Act for each failure or refusal to file a completed report required to be filed under section 101(g) and 29 CFR 2520.101–2. The term “administrator” is defined in 29 CFR 2520.101–2(b).

(2) For purposes of this section, a failure or refusal to file the report required to be filed under section 101(g) shall mean a failure or refusal to file, in whole or in part, that information described in section 101(g) and 29 CFR 2520.101–2, on behalf of the MEWA, at the time and in the manner prescribed therefor.

(b) Amount assessed—(1) The amount assessed under section 502(c)(5) shall be determined by the Department of Labor, taking into consideration the degree and/or willfulness of the failure to file the report. However, the amount assessed under section 502(c)(5) of the Act shall not exceed $1,000 a day, computed from the date of the administrator’s failure or refusal to file the report and, except as provided in paragraph (b)(2) of this section, continuing up to the date on which a report meeting the requirements of section 101(g) and 29 CFR 2520.101–2, as determined by the Secretary, is filed.

(2) Amount assessed—(1) The amount assessed under section 502(c)(5) shall be determined by the Department of Labor, taking into consideration the degree and/or willfulness of the failure to file the report. However, the amount assessed under section 502(c)(5) of the Act shall not exceed $1,000 a day, computed from the date of the administrator’s failure or refusal to file the report and, except as provided in paragraph (b)(2) of this section, continuing up to the date on which a report meeting the requirements of section 101(g) and 29 CFR 2520.101–2, as determined by the Secretary, is filed.

(2) If, upon receipt of a notice of intent to assess a penalty (as described in paragraph (c) of this section), the administrator files a statement of reasonable cause for the failure to file, in accordance with paragraph (e) of this section, a penalty shall not be assessed for any day from the date the Department serves the administrator with a copy of such notice until the day after the Department serves notice on the administrator of its determination on reasonable cause and its intention to assess a penalty (as described in paragraph (g) of this section).

(3) For purposes of this paragraph, the date on which the administrator failed or refused to file the report shall be the date on which the report was due (determined without regard to any extension of time for filing). A report which is rejected under 29 CFR 2520.101–2 shall be treated as a failure to file a report when a revised report meeting the requirements of this section is not filed within 45 days of the date of the Department’s notice of rejection. If a revised report meeting the requirements of this section, as determined by the Secretary, is not submitted within 45 days of the date of the notice of rejection by the Department, a penalty shall be assessed under section 502(c)(5) beginning on the day after the date of the administrator’s failure or refusal to file the report.

(c) Notice of intent to assess a penalty. Prior to the assessment of any penalty under section 502(c)(5), the Department shall provide to the administrator of the MEWA a written notice indicating the Department’s intent to assess a penalty under section 502(c)(5), the amount of such penalty, the period to which the penalty applies, and a statement of the facts and the reason(s) for the penalty.

(d) Reconsideration or waiver of penalty to be assessed. The Department may determine that all or part of the penalty amount in the notice of intent to assess a penalty shall not be assessed on a showing that the administrator complied with the requirements of section 101(g) of the Act or on a showing by the administrator of mitigating circumstances regarding the degree or willfulness of the noncompliance.

(e) Showing of reasonable cause. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have thirty (30) days from the date of service of the notice, as described in paragraph (d) of this section, to file a statement of reasonable cause explaining why the penalty, as calculated, should be reduced, or not be assessed, for the reasons set forth in paragraph (d) of this section. Such statement must be made in writing and
set forth all the facts alleged as reasonable cause for the reduction or non-assessment of the penalty. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) Failure to file a statement of reasonable cause. Failure of an administrator to file a statement of reasonable cause within the thirty (30) day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice of intent, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(5) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of 29 CFR 2570.91(g), forty-five (45) days from the date of service of the notice.

(g) Notice of the determination on statement of reasonable cause—(1) The Department, following a review of all the facts alleged in support of no assessment or a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its determination to waive the penalty, in whole or in part, and/or assess a penalty. If it is the determination of the Department to assess a penalty, the notice shall indicate the amount of the penalty, not to exceed the amount described in paragraph (c) of this section, and a brief statement of the reasons for assessing the penalty. This notice is a “pleading” for purposes of 29 CFR 2570.91(m).

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) of this section, indicating the Department’s intention to assess a penalty, shall become a final order, within the meaning of 29 CFR 2570.91(g), forty-five (45) days from the date of service of the notice.

(h) Administrative hearing. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of 29 CFR 2570.91(g), if, within thirty (30) days from the date of the service of the notice, the administrator or a representative thereof files a request for a hearing under 29 CFR 2570.90 through 2570.101, and files an answer to the notice. The request for hearing and answer must be filed in accordance with 29 CFR 2570.92 and 18.4. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) Service of notices and filing of statements—(1) Service of a notice for purposes of paragraphs (c) and (g) of this section shall be made:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is by regular mail, service is complete upon receipt by the addressee. When service of a notice under paragraph (c) or (g) of this section is by certified mail, five (5) days shall be added to the time allowed by these rules for the filing of a statement, or a request for hearing and answer, as applicable.

(3) For purposes of this section, a statement of reasonable cause shall be considered filed:

(i) Upon mailing, if accomplished using United States Postal Service certified mail or Express Mail;

(ii) Upon receipt by the delivery service, if accomplished using a “designated private delivery service” within the meaning of 26 U.S.C. 7502(f);

(iii) Upon transmittal, if transmitted in a manner specified in the notice of intent to assess a penalty as a method of transmittal to be accorded such special treatment; or

(iv) In the case of any other method of filing, upon receipt by the Department at the address provided in the notice of intent to assess a penalty.

(j) Liability—(1) If more than one person is responsible as administrator for the failure to file the report, all such persons shall be jointly and severally liable with respect to such failure.
(2) Any person against whom a civil penalty has been assessed under section 502(c)(5) pursuant to a final order, within the meaning of 29 CFR 2570.91(g), shall be personally liable for the payment of such penalty.


[68 FR 17505, Apr. 9, 2003]

§ 2560.502c–6 Civil penalties under section 502(c)(6).

(a) In general. (1) Pursuant to the authority granted the Secretary under section 502(c)(6) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator (within the meaning of section 3(16)(A) of the Act) of an employee benefit plan (within the meaning of section 3(3) of the Act and § 2510.3–1 of this chapter) shall be liable for civil penalties assessed by the Secretary under section 502(c)(6) of the Act in each case in which there is a failure or refusal to furnish to the Secretary documents requested under section 104(a)(6) of the Act and § 2520.104a–8 of this chapter.

(2) For purposes of this section, a failure or refusal to furnish documents shall mean a failure or refusal to furnish, in whole or in part, the documents requested under section 104(a)(6) of the Act at the time and in the manner prescribed in the request.

(b) Amount assessed. (1) The amount assessed under section 502(c)(6) of the Act shall be determined by the Department of Labor, taking into consideration the degree and/or willfulness of the failure or refusal to furnish any document or documents requested by the Department under section 104(a)(6) of the Act. However, the amount assessed under section 502(c)(6) of the Act shall not exceed $100 a day or $1,000 per request (or such other maximum amounts as may be established by regulation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended), computed from the date of the administrator’s failure or refusal to furnish any document or documents requested by the Department.

(2) For purposes of calculating the amount to be assessed under this section, the date of a failure or refusal to furnish documents shall not be earlier than the thirtieth day after service of the request under section 104(a)(6) of ERISA and § 2520.104a–8 of this chapter.

(c) Notice of intent to assess a penalty. Prior to the assessment of any penalty under section 502(c)(6) of the Act, the Department shall provide to the administrator of the plan a written notice that indicates the Department’s intent to assess a penalty under section 502(c)(6) of the Act, the amount of the penalty, the period to which the penalty applies, and the reason(s) for the penalty.

(d) Reconsideration or waiver of penalty to be assessed. The Department may determine that all or part of the penalty amount in the notice of intent to assess a penalty shall not be assessed on a showing that the administrator complied with the requirements of section 104(a)(6) of the Act or on a showing by the administrator of mitigating circumstances regarding the degree or willfulness of the noncompliance.

(e) Showing of reasonable cause. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have thirty (30) days from the date of service of the notice, as described in paragraph (i) of this section, to file a statement of reasonable cause explaining why the penalty, as calculated, should be reduced or not be assessed, for the reasons set forth in paragraph (d) of this section. Such statement must be made in writing and set forth all the facts alleged as reasonable cause for the reduction or non-assessment of the penalty. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) Failure to file a statement of reasonable cause. Failure to file a statement of reasonable cause within the 30 day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice of intent, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(6) of the Act. Such notice shall then become a final order of the Secretary, within
the meaning of §2570.111(g) of this chapter, forty-five (45) days from the date of service of the notice.

(g) Notice of determination on statement of reasonable cause. (1) The Department, following a review of all of the facts alleged in support of no assessment or a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its determination not to assess or to waive the penalty, in whole or in part, and/or assess a penalty. If it is the determination of the Department to assess a penalty, the notice shall indicate the amount of the penalty, not to exceed the amount described in paragraph (c) of this section. This notice is a “pleading” for purposes of §2570.111(m) of this chapter.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) of this section, indicating the Department’s intention to assess a penalty, shall become a final order, within the meaning of §2570.111(g) of this chapter, forty-five (45) days from the date of service of the notice.

(h) Administrative hearing. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of §2570.111(g) of this chapter, if, within thirty (30) days from the date of service of the notice, the administrator or a representative thereof files a request for a hearing under §§2570.110 through 2570.121 of this chapter, and files an answer to the notice. The request for hearing and answer must be filed in accordance with §2570.112 of this chapter and §18.4 of this title. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) Service of notices and filing of statements. (1) Service of a notice for purposes of paragraphs (c) and (g) of this section shall be made:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is by regular mail, service is complete upon receipt by the addressee. When service of a notice under paragraph (c) or (g) of this section is by certified mail, five (5) days shall be added to the time allowed by these rules for the filing of a statement, or a request for hearing and answer, as applicable.

(3) For purposes of this section, a statement of reasonable cause shall be considered filed:

(i) Upon mailing, if accomplished using United States Postal Service certified mail or Express Mail;

(ii) Upon receipt by the delivery service, if accomplished using a “designated private delivery service” within the meaning of 26 U.S.C. 7502(c);

(iii) Upon transmittal, if transmitted in a manner specified in the notice of intent to assess a penalty as a method of transmittal to be accorded such special treatment; or

(iv) In the case of any other method of filing, upon receipt by the Department at the address provided in the notice of intent to assess a penalty.

(j) Liability. (1) If more than one person is responsible as administrator for the failure to furnish the document or documents requested under section 104(a)(6) of the Act and its implementing regulations (§2520.104a-8 of this chapter), all such persons shall be jointly and severally liable with respect to such failure.

(2) Any person, or persons under paragraph (j)(1) of this section, against whom a civil penalty has been assessed under section 502(c)(6) of the Act pursuant to a final order, within the meaning of §2570.111(g) of this chapter, shall be personally liable for the payment of such penalty.

(k) Cross-reference. See §§2570.110 through 2570.121 of this chapter for procedural rules relating to administrative hearings under section 502(c)(6) of the Act.

§ 2560.502c–7 Civil penalties under section 502(c)(7).

(a) In general. (1) Pursuant to the authority granted the Secretary under section 502(c)(7) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator (within the meaning of section 3(16)(A) of the Act) of an individual account plan (within the meaning of section 101(i)(8) of the Act and §2520.101–3(d)(2) of this chapter), who fails or refuses to provide notice of a blackout period to affected participants and beneficiaries in accordance with section 101(i) of the Act and §2520.101–3 of this chapter, or the administrator (within the meaning of section 3(16)(A) of the Act) of an applicable individual account plan (within the meaning of section 101(m) of the Act), who fails or refuses to provide notice of diversification rights to applicable individuals in accordance with section 101(m) of the Act, shall be liable for civil penalties assessed by the Secretary under section 502(c)(7) of the Act.

(2) For purposes of this section, a failure or refusal to provide a notice of blackout period shall mean a failure or refusal, in whole or in part, to provide notice of a blackout period to an affected plan participant or beneficiary at the time and in the manner prescribed by section 101(i) of the Act and §2520.101–3 of this chapter, and a failure or refusal to provide a notice of diversification rights shall mean a failure or refusal, in whole or in part, to provide notice of diversification rights to applicable individuals in accordance with section 101(m) of the Act.

(b) Amount assessed. (1) The amount assessed under section 502(c)(7) of the Act for each separate violation shall be determined by the Department of Labor, taking into consideration the degree and/or willfulness of the failure or refusal to provide a notice of blackout period or notice of diversification rights. However, the amount assessed for each violation under section 502(c)(7) of the Act shall not exceed $100 a day (or such other maximum amount as may be established by regulation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended), computed from, in the case of a notice of blackout period under section 101(i) of the Act, the date of the administrator’s failure or refusal to provide a notice of blackout period up to and including the date that is the final day of the blackout period for which the notice was required, or in the case of a notice of diversification rights under section 101(m) of the Act, computed from the date that is 30 days before the first date on which rights are exercisable under section 204(j) of the Act up to the date such a notice is furnished.

(2) For purposes of calculating the amount to be assessed under this section, a failure or refusal to provide a notice of blackout period or a notice of diversification rights with respect to any single participant or beneficiary shall be treated as a separate violation under section 101(i) of the Act and §2520.101–3 of this chapter or section 101(m) of the Act.

(c) Notice of intent to assess a penalty. Prior to the assessment of any penalty under section 502(c)(7) of the Act, the Department shall provide to the administrator of the plan a written notice indicating the Department’s intent to assess a penalty under section 502(c)(7) of the Act, the amount of such penalty, the number of participants and beneficiaries on which the penalty is based, the period to which the penalty applies, and the reason(s) for the penalty.

(d) Reconsideration or waiver of penalty to be assessed. The Department may determine that all or part of the penalty amount in the notice of intent to assess a penalty shall not be assessed on a showing that the administrator complied with the applicable requirements of section 101(i) or section 101(m) of the Act or on a showing by the administrator of mitigating circumstances regarding the degree or willfulness of the noncompliance.

(e) Showing of reasonable cause. Upon issuance by the Department of a notice of intent to assess a penalty, the administrator shall have thirty (30) days from the date of service of the notice, as described in paragraph (i) of this section, to file a statement of reasonable cause explaining why the penalty, as calculated, should be reduced, or not be assessed, for the reasons set forth in
paragraph (d) of this section. Such statement must be made in writing and set forth all the facts alleged as reasonable cause for the reduction or non-assessment of the penalty. The statement must contain a declaration by the administrator that the statement is made under the penalties of perjury.

(f) Failure to file a statement of reasonable cause. Failure to file a statement of reasonable cause within the 30 day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice of intent, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(7) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of §2570.131(g) of this chapter, forty-five (45) days from the date of service of the notice.

(g) Notice of determination on statement of reasonable cause. (1) The Department, following a review of all of the facts in a statement of reasonable cause alleged in support of no assessment or a complete or partial waiver of the penalty, shall notify the administrator, in writing, of its determination on the statement of reasonable cause and its determination whether to waive the penalty in whole or in part, and/or assess a penalty. If it is the determination of the Department to assess a penalty, the notice shall indicate the amount of the penalty assessment, not to exceed the amount described in paragraph (c) of this section. This notice is a “pleading” for purposes of §2570.131(m) of this chapter.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) of this section, indicating the Department’s determination to assess a penalty, shall become a final order, within the meaning of §2570.131(g) of this chapter, forty-five (45) days from the date of service of the notice.

(h) Administrative hearing. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of §2570.131(g) of this chapter, if, within thirty (30) days from the date of the service of the notice, the administrator or a representative thereof files a request for a hearing under §§2570.130 through 2570.141 of this chapter, and files an answer to the notice. The request for hearing and answer must be filed in accordance with §2570.132 of this chapter and §18.4 of this title. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) Service of notices and filing of statements. (1) Service of a notice for purposes of paragraphs (c) and (g) of this section shall be made:

(i) By delivering a copy to the administrator or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the administrator or representative thereof; or

(iii) By mailing a copy to the last known address of the administrator or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is by regular mail, service is complete upon receipt by the addressee. When service of a notice under paragraph (c) or (g) of this section is by certified mail, five (5) days shall be added to the time allowed by these rules for the filing of a statement or a request for hearing and answer, as applicable.

(3) For purposes of this section, a statement of reasonable cause shall be considered filed:

(i) Upon mailing, if accomplished using United States Postal Service certified mail or Express Mail;

(ii) Upon receipt by the delivery service, if accomplished using a “designated private delivery service” within the meaning of 26 U.S.C. 7502(f);

(iii) Upon transmittal, if transmitted in a manner specified in the notice of intent to assess a penalty as a method of transmittal to be accorded such special treatment; or

(iv) In the case of any other method of filing, upon receipt by the Department at the address provided in the notice of intent to assess a penalty.

(j) Liability. (1) If more than one person is responsible as administrator for
the failure to provide a notice of black-out period under section 101(i) of the Act and its implementing regulations (§2520.101–3 of this chapter), or the failure to provide a notice of diversification rights under section 101(m) of the Act, all such persons shall be jointly and severally liable for such failure.

(2) Any person, or persons under paragraph (j)(1) of this section, against whom a civil penalty has been assessed under section 502(c)(7) of the Act, pursuant to a final order, within the meaning of §2570.131(g) of this chapter, shall be personally liable for the payment of such penalty.

(k) Cross-reference. See §§2570.130 through 2570.141 of this chapter for procedural rules relating to administrative hearings under section 502(c)(7) of the Act.

§ 2560.502c–8 Civil penalties under section 502(c)(8).

(a) In general. (1) Pursuant to the authority granted the Secretary under section 502(c)(8) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the plan sponsor (within the meaning of section 3(16)(B)(iii) of the Act) shall be liable for civil penalties assessed by the Secretary under section 502(c)(8) of the Act, for:

(i) Each violation by such sponsor of the requirement under section 305 of the Act to adopt by the deadline established in that section a funding improvement plan or rehabilitation plan with respect to a multiemployer plan which is in endangered or critical status; or

(ii) In the case of a plan in endangered status which is not in seriously endangered status, a failure by the plan to meet the applicable benchmarks under section 305 by the end of the funding improvement period with respect to the plan.

(2) For purposes of this section, violations or failures referred to in paragraph (a)(1) of this section shall mean a failure or refusal, in whole or in part, to adopt a funding improvement or rehabilitation plan, or to meet the applicable benchmarks, at the relevant times and manners prescribed in section 305 of the Act.

(b) Amount assessed. The amount assessed under section 502(c)(8) of the Act for each separate violation shall be determined by the Department of Labor, taking into consideration the degree or willfulness of the failure or refusal to comply with the specific requirements referred to in paragraph (a) of this section. However, the amount assessed for each violation under section 502(c)(8) of the Act shall not exceed $1,100 a day (or such other maximum amount as may be established by regulation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended), computed from the date of the plan sponsor’s failure or refusal to comply with the specific requirements referred to in paragraph (a) of this section.

(c) Notice of intent to assess a penalty. Prior to the assessment of any penalty under section 502(c)(8) of the Act, the Department shall provide to the plan sponsor of the plan a written notice indicating the Department’s intent to assess a penalty under section 502(c)(8) of the Act, the amount of such penalty, the period to which the penalty applies, and the reason(s) for the penalty.

(d) Reconsideration or waiver of penalty to be assessed. The Department may determine that all or part of the penalty amount in the notice of intent to assess a penalty shall not be assessed on a showing that the plan sponsor complied with the requirements of section 305 of the Act, or on a showing by the plan sponsor of mitigating circumstances regarding the degree or willfulness of the noncompliance.

(e) Showing of reasonable cause. Upon issuance by the Department of a notice of intent to assess a penalty, the plan sponsor shall have thirty (30) days from the date of service of the notice, as described in paragraph (i) of this section, to file a statement of reasonable cause explaining why the penalty, as calculated, should be reduced, or not be assessed, for the reasons set forth in paragraph (d) of this section. Such statement must be made in writing and set forth all the facts alleged as reasonable cause for the reduction or non-assessment of the penalty. The statement must contain a declaration by
the plan sponsor that the statement is made under the penalties of perjury.

(f) Failure to file a statement of reasonable cause. Failure to file a statement of reasonable cause within the thirty (30) day period described in paragraph (e) of this section shall be deemed to constitute a waiver of the right to appear and contest the facts alleged in the notice of intent, and such failure shall be deemed an admission of the facts alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(8) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of §2570.161(g) of this chapter, forty-five (45) days from the date of service of the notice.

(g) Notice of determination on statement of reasonable cause. (1) The Department, following a review of all of the facts in a statement of reasonable cause alleged in support of nonassessment or a complete or partial waiver of the penalty, shall notify the plan sponsor, in writing, of its determination on the statement of reasonable cause and its determination whether to waive the penalty in whole or in part, and/or assess a penalty. If it is the determination of the Department to assess a penalty, the notice shall indicate the amount of the penalty assessment, not to exceed the amount described in paragraph (c) of this section. This notice is a "pleading" for purposes of §2570.161(m) of this chapter.

(2) Except as provided in paragraph (h) of this section, a notice issued pursuant to paragraph (g)(1) of this section, indicating the Department's determination to assess a penalty, shall become a final order, within the meaning of §2570.161(g) of this chapter, forty-five (45) days from the date of service of the notice.

(h) Administrative hearing. A notice issued pursuant to paragraph (g) of this section will not become a final order, within the meaning of §2570.161(g) of this chapter, if, within thirty (30) days from the date of the service of the notice, the plan sponsor or a representative thereof files a request for a hearing under §§2570.160 through 2570.171 of this chapter, and files an answer to the notice. The request for hearing and answer must be filed in accordance with §2570.162 of this chapter and §18.4 of this title. The answer opposing the proposed sanction shall be in writing, and supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to paragraph (g) of this section.

(i) Service of notices and filing of statements. (1) Service of a notice for purposes of paragraphs (c) and (g) of this section shall be made:

(i) By delivering a copy to the plan sponsor or representative thereof;

(ii) By leaving a copy at the principal office, place of business, or residence of the plan sponsor or representative thereof; or

(iii) By mailing a copy to the last known address of the plan sponsor or representative thereof.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is by regular mail, service is complete upon receipt by the addressee. When service of a notice under paragraph (c) or (g) of this section is by certified mail, five days shall be added to the time allowed by these rules for the filing of a statement or a request for hearing and answer, as applicable.

(3) For purposes of this section, a statement of reasonable cause shall be considered filed:

(i) Upon mailing, if accomplished using United States Postal Service certified mail or express mail;

(ii) Upon receipt by the delivery service, if accomplished using a "designated private delivery service" within the meaning of 26 U.S.C. 7502(f);

(iii) Upon transmittal, if transmitted in a manner specified in the notice of intent to assess a penalty as a method of transmittal to be accorded such special treatment; or

(iv) In the case of any other method of filing, upon receipt by the Department at the address provided in the notice of intent to assess a penalty.

(j) Liability. (1) If more than one person is responsible as plan sponsor for violations referred to in paragraph (a) of this section, all such persons shall be jointly and severally liable for such violations.

(2) Any person, or persons under paragraph (j)(1) of this section, against
whom a civil penalty has been assessed under section 502(c)(8) of the Act, pursuant to a final order within the meaning of §2570.161(g) of this chapter, shall be personally liable for the payment of such penalty.

(k) Cross-reference. See §§2570.160 through 2570.171 of this chapter for procedural rules relating to administrative hearings under section 502(c)(8) of the Act.

[75 FR 8800, Feb. 26, 2010]

§2560.502i–1 Civil penalties under section 502(i).

(a) In general. Section 502(i) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) permits the Secretary of Labor to assess a civil penalty against a party in interest who engages in a prohibited transaction with respect to an employee benefit plan other than a plan described in section 4975(e)(1) of the Internal Revenue Code (the Code). The initial penalty under section 502(i) is five percent of the total “amount involved” in the prohibited transaction (unless a lesser amount is otherwise agreed to by the parties). However, if the prohibited transaction is not corrected during the “correction period,” the civil penalty shall be 100 percent of the “amount involved” (unless a lesser amount is otherwise agreed to by the parties). Paragraph (b) of this section defines the term “amount involved,” paragraph (c) defines the term “correction,” and paragraph (d) defines the term “correction period.” Paragraph (e) illustrates the computation of the civil penalty under section 502(i). Paragraph (f) is a cross reference to the Department’s procedural rules for section 502(i) proceedings.

(b) Amount involved. Section 502(i) of ERISA states that the term “amount involved” in that section shall be defined as it is defined under section 4975(f)(4) of the Code. As provided in 26 CFR 141.4975–13, 26 CFR 53.4941(e)–1(b) is controlling with respect to the interpretation of the term “amount involved” under section 4975 of the Code. Accordingly, the Department of Labor will apply the principles set out in 26 CFR 53.4941(e)–1(c) in interpreting the term “correction” under section 502(i) of the Act and this section.

(c) Correction. Section 502(i) of ERISA states that the term “correction” shall be defined in a manner that is consistent with the definition of that term under section 4975(f)(5) of the Code. As provided in 26 CFR 141.4975–13, 26 CFR 53.4941(e)–1(c) is controlling with respect to the interpretation of the term “correction” for purposes of section 4975 of the Code. Accordingly, the Department of Labor will apply the principles set out in 26 CFR 53.4941(e)–1(c) in interpreting the term “correction” under section 502(i) of the Act and this section.

(d) Correction period. (1) In general, the “correction period” begins on the date the prohibited transaction occurs and ends 90 days after a final agency order with respect to such transaction.

(2) When a party in interest seeks judicial review within 90 days of a final agency order in an ERISA section 502(i) proceeding, the correction period will end 90 days after the entry of a final order in the judicial action.

(3) The following examples illustrate the operation of this paragraph:

(i) A party in interest receives notice of the Department’s intent to impose the section 502(i) penalty and does not invoke the ERISA section 502(i) prohibited transaction penalty proceedings described in §2570.1 of this chapter within 30 days of such notice. As provided in §2570.3 of this chapter, the notice of the intent to impose a penalty becomes a final order after 30 days. Thus, the “correction period” ends 90 days after the expiration of the 30 day period.

(ii) A party in interest contests a proposed section 502(i) penalty, but does not appeal an adverse decision of the administrative law judge in the proceeding. As provided in §2570.16(a) of this chapter, the decision of the administrative law judge becomes a final order of the Department unless the decision is appealed within 20 days after the date of such order. Thus, the correction period ends 90 days after the expiration of such 20 day period.

(iii) The Secretary of Labor issues to a party in interest a decision upholding an adverse decision of the administrative law judge’s adverse decision. As provided in §2570.12(b) of this chapter, the decision of the Secretary becomes a final order of the Department immediately. Thus, the correction period will end 90 days after the issuance of the Secretary’s order unless the party in interest judicially contests the order within that 90 day period. If the party...
in interest so contests the order, the correction period will end 90 days after the entry of a final order in the judicial action.

(e) Computation of the section 502(i) penalty. (1) In general, the civil penalty under section 502(i) is determined by applying the applicable percentage (five percent or one hundred percent) to the aggregate amount involved in the transaction. However, a continuing prohibited transaction, such as a lease or a loan, is treated as giving rise to a separate event subject to the sanction for each year (as measured from the anniversary date of the transaction) in which the transaction occurs.

(2) The following examples illustrate the computation of the section 502(i) penalty:

(i) An employee benefit plan purchases property from a party in interest at a price of $10,000. The fair market value of the property is $5,000. The “amount involved” in that transaction, as determined under 26 CFR 53.4941(e)–1(b), is $10,000 (the greater of the amount paid by the plan or the fair market value of the property). The initial five percent penalty under section 502(i) is $500 (five percent of $10,000).

(ii) An employee benefit plan executes a four year lease with a party in interest at an annual rental of $10,000 (which is the fair rental value of the property). The amount involved in each year of that transaction, as determined under 26 CFR 53.4941(e)–1(b), is $10,000. The amount of the initial sanction under ERISA section 502(i) would be a total of $5,000: $2,000 ($10,000 × 5% × 4 with respect to the rentals paid in the first year of the lease); $1,500 ($10,000 × 5% × 3 with respect to the second year); $1,000 ($10,000 × 5% × 2 with respect to the third year); $500 ($10,000 × 5% × 1 with respect to the fourth year).

(f) Cross reference. See §§2570.1–2570.12 of this chapter for procedural rules relating to section 502(i) penalty proceedings.

[53 FR 37476, Sept. 26, 1988]

§ 2560.503–1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

(2) A description of all claims procedures (including, in the case of a group health plan within the meaning of paragraph (m)(6) of this section, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures) and the applicable time frames is included as part of a summary plan description meeting the requirements of 29 CFR 2520.102–3.

(3) The claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits. For example, a provision or practice that requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination would be considered to unduly inhibit the initiation and processing of claims for benefits. Also, the denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant (e.g., in the case of a group health plan, the claimant is unconscious and in need of immediate care at the time medical treatment is required) would...
constitute a practice that unduly inhibits the initiation and processing of a claim;

(4) The claims procedures do not preclude an authorized representative of a claimant from acting on behalf of such claimant in pursuing a benefit claim or appeal of an adverse benefit determination. Nevertheless, a plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, in the case of a claim involving urgent care, within the meaning of paragraph (m)(1) of this section, a health care professional, within the meaning of paragraph (m)(7) of this section, with knowledge of a claimant’s medical condition shall be permitted to act as the authorized representative of the claimant; and

(5) The claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants.

(6) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees)—

(i) Such plan will be deemed to comply with the provisions of paragraphs (c) through (j) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference—

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which adverse benefit determinations are subject (but not provisions concerning the filing and initial disposition of benefit claims).

(c) Group health plans. The claims procedures of a group health plan will be deemed to be reasonable only if, in addition to complying with the requirements of paragraph (b) of this section—

(1)(i) The claims procedures provide that, in the case of a failure by a claimant or an authorized representative of a claimant to follow the plan’s procedures for filing a pre-service claim, within the meaning of paragraph (m)(2) of this section, the claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

(ii) Paragraph (c)(1)(i) of this section shall apply only in the case of a failure that—

(A) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and

(B) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

(2) The claims procedures do not contain any provision, and are not administered in a way, that requires a claimant to file more than two appeals of an adverse benefit determination prior to bringing a civil action under section 502(a) of the Act;

(3) To the extent that a plan offers voluntary levels of appeal (except to the extent that the plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, in addition to those
permitted by paragraph (c)(2) of this section, the claims procedures provide that:

(i) The plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to submit a benefit dispute to any such voluntary level of appeal provided by the plan;

(ii) The plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

(iii) The claims procedures provide that a claimant may elect to submit a benefit dispute to such voluntary level of appeal only after exhaustion of the appeals permitted by paragraph (c)(2) of this section;

(iv) The plan provides to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant’s rights to any other benefits under the plan and information about the applicable rules, the claimant’s right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and

(v) No fees or costs are imposed on the claimant as part of the voluntary level of appeal.

(4) The claims procedures do not contain any provision for the mandatory arbitration of adverse benefit determinations, except to the extent that the plan or procedures provide that:

(i) The arbitration is conducted as one of the two appeals described in paragraph (c)(2) of this section and in accordance with the requirements applicable to such appeals; and

(ii) The claimant is not precluded from challenging the decision under section 502(a) of the Act or other applicable law.

(d) Plans providing disability benefits. The claims procedures of a plan that provides disability benefits will be deemed to be reasonable only if the claims procedures comply, with respect to claims for disability benefits, with the requirements of paragraphs (b), (c)(2), (c)(3), and (c)(4) of this section.

(e) Claim for benefits. For purposes of this section, a claim for benefits is a request for a plan benefit or benefits made by a claimant in accordance with a plan’s reasonable procedure for filing benefit claims. In the case of a group health plan, a claim for benefits includes any pre-service claims within the meaning of paragraph (m)(2) of this section and any post-service claims within the meaning of paragraph (m)(3) of this section.

(f) Timing of notification of benefit determination—(1) In general. Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly or partially denied, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan’s adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the benefit determination.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan’s benefit determination in accordance with paragraph (f)(2)(i), (f)(2)(ii), or (f)(2)(iii) of this section, as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant of the plan’s benefit determination (whether adverse or not) as soon as
possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the plan administrator shall notify the claimant as soon as possible, but not later than 72 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(i) shall be made in accordance with paragraph (g) of this section. The plan administrator shall notify the claimant of the adverse benefit determination as soon as possible, but in no case later than 48 hours after the earlier of—

(A) The plan’s receipt of the specified information, or
(B) The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent care decisions. If a group health plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments—

(A) Any reduction or termination by the plan of such course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

(B) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the plan administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with paragraph (g) of this section, and appeal shall be governed by paragraph (i)(2)(i), (i)(2)(ii), or (i)(2)(iii), as appropriate.

(iii) Other claims. In the case of a claim not described in paragraphs (f)(2)(i) or (f)(2)(ii) of this section, the plan administrator shall notify the claimant of the plan’s benefit determination in accordance with either paragraph (f)(2)(iii)(A) or (f)(2)(iii)(B) of this section, as appropriate.

(A) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan’s benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (f)(2)(iii)(A) shall be made in accordance with paragraph (g) of this section.
§2560.503–1

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan’s adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(3) Disability claims. In the case of a claim for disability benefits, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan’s adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the plan. This period may be extended by the plan for up to 30 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If, prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the plan administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision.

In the case of any extension under this paragraph (f)(3), the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(4) Calculating time periods. For purposes of paragraph (f) of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (f)(2)(iii) or (f)(3) of this section due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b–1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a)
of the Act following an adverse benefit determination on review:

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations—(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part
on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan’s benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(i) through (iv) and (h)(3)(i) through (v) of this section.

(i) Timing of notification of benefit determination on review—(1) In general. (i) Except as provided in paragraphs (j)(1)(i), (j)(2), and (j)(3) of this section, the plan administrator shall notify a claimant in accordance with paragraph (j) of this section of the plan’s benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant’s request for review by the plan, unless the plan administrator determines that special circumstances (such as the need to hold a hearing, if the plan’s procedures provide for a hearing) require an extension of time for processing the claim. If the plan administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (j)(1)(i) of this section shall not apply, and, except as provided in paragraphs (j)(2) and (j)(3) of this section, the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan’s receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan’s procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan’s receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement.
Employee Benefits Security Admin., Labor § 2560.503–1

of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(2) Group health plans. In the case of a group health plan, the plan administrator shall notify a claimant of the plan’s benefit determination on review in accordance with paragraphs (i)(2)(i) through (iii), as appropriate.

(i) Urgent care claims. In the case of a claim involving urgent care, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan’s benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant’s request for review of an adverse benefit determination by the plan.

(ii) Pre-service claims. In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan’s benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant’s request for review of the adverse benefit determination.

(iii) Post-service claims. (A) In the case of a post-service claim, except as provided in paragraph (i)(2)(iii)(B) of this section, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan’s benefit determination on review within a reasonable period of time. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 60 days after receipt by the plan of the claimant’s request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 30 days after receipt by the plan of the claimant’s request for review of the adverse determination.

(B) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(2)(iii)(A) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan’s receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan’s procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan’s receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(3) Disability claims. (i) Except as provided in paragraph (i)(3)(ii) of this section, claims involving disability benefits (whether the plan provides for one or two appeals) shall be governed by paragraph (i)(1) of this section, except
that a period of 45 days shall apply instead of 60 days for purposes of that paragraph.

(ii) In the case of a multiemployer plan with a committee or board of trustees designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, paragraph (i)(3)(i) of this section shall not apply, and the appropriate named fiduciary shall instead make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan’s receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan’s receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan’s procedures provide for a hearing) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan’s receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall notify the claimant in writing of the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(4) Calculating time periods. For purposes of paragraph (i) of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted pursuant to paragraph (i)(1), (i)(2)(iii)(B), or (i)(3) of this section due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(5) Furnishing documents. In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate.

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notification of a plan’s benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant’s right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such
rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

(k) Preemption of State law. (1) Nothing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section.

(2)(i) For purposes of paragraph (k)(1) of this section, a State law regulating insurance shall not be considered to prevent the application of a requirement of this section merely because such State law establishes a review procedure to evaluate and resolve disputes involving adverse benefit determinations under group health plans so long as the review procedure is conducted by a person or entity other than the insurer, the plan, plan fiduciaries, the employer, or any employee or agent of any of the foregoing.

(ii) The State law procedures described in paragraph (k)(2)(i) of this section are not part of the full and fair review required by section 503 of the Act. Claimants therefore need not exhaust such State law procedures prior to bringing suit under section 502(a) of the Act.

(l) Failure to establish and follow reasonable claims procedures. In the case of the failure of a plan to establish or follow claims procedures consistent with the requirements of this section, a claimant shall be deemed to have exhausted the administrative remedies available under the plan and shall be entitled to pursue any available remedies under section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(m) Definitions. The following terms shall have the meaning ascribed to such terms in this paragraph (m) whenever such term is used in this section:

(1)(i) A “claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations—

(A) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or,

(B) In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(ii) Except as provided in paragraph (m)(1)(iii) of this section, whether a claim is a “claim involving urgent care” within the meaning of paragraph (m)(1)(i)(A) of this section is to be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(iii) Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” within the meaning of paragraph (m)(1)(i)(A) of this section shall be treated as a “claim involving urgent care” for purposes of this section.

(2) The term “pre-service claim” means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(3) The term “post-service claim” means any claim for a benefit under a group health plan that is not a pre-
(4) The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(5) The term “notice” or “notification” means the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b–1(b) as appropriate with respect to material required to be furnished or made available to an individual.

(6) The term “group health plan” means an employee welfare benefit plan within the meaning of section 3(1) of the Act to the extent that such plan provides “medical care” within the meaning of section 733(a) of the Act.

(7) The term “health care professional” means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

(8) A document, record, or other information shall be considered “relevant” to a claimant’s claim if such document, record, or other information

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) Demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination; or

(iv) In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

(n) Apprenticeship plans. This section does not apply to employee benefit plans that solely provide apprenticeship training benefits.

(o) Applicability dates. (1) Except as provided in paragraph (o)(2) of this section, this section shall apply to claims filed under a plan on or after January 1, 2002.

(2) This section shall apply to claims filed under a group health plan on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003.

[65 FR 70265, Nov. 21, 2000, as amended at 66 FR 35887, July 9, 2001]
issuance of such cease and desist orders.

(b) Definitions. When used in this section, the following terms shall have the meanings ascribed in this paragraph (b).

(1) **Multiple employer welfare arrangement (MEWA)** is an arrangement as defined in section 3(40) of ERISA that either is an employee welfare benefit plan subject to Title I of ERISA or offers benefits in connection with one or more employee welfare benefit plans subject to Title I of ERISA. For purposes of section 521 of ERISA, a MEWA does not include a health insurance issuer (including a health maintenance organization) that is licensed to offer or provide health insurance coverage to the public and employers at large in each State in which it offers or provides health insurance coverage, and that, in each such State, is subject to comprehensive licensure, solvency, and examination requirements that the State customarily requires for issuing health insurance policies to the public and employers at large. The term health insurance issuer does not include group health plans. For purposes of this section, the term “health insurance coverage” has the same meaning as in ERISA section 733(b)(1).

(2) **The conduct of a MEWA is fraudulent:**

(i) When the MEWA or any person acting as an agent or employee of the MEWA commits an act or omission knowingly and with an intent to deceive or defraud plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, the Secretary, or a State regarding:

(A) The financial condition of the MEWA (including the MEWA’s solvency and the management of plan assets);

(B) The benefits provided by or in connection with the MEWA;

(C) The management, control, or administration of the MEWA;

(D) The existing or lawful regulatory status of the MEWA under Federal or State law;

(E) Any other material fact, as determined by the Secretary, relating to the MEWA or its operation.

(ii) Fraudulent conduct includes any false statement regarding any of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section that is made with knowledge of its falsity or that is made with reckless indifference to the statement’s truth or falsity, and the knowing concealment of material information regarding any of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section. Examples of fraudulent conduct include, but are not limited to, misrepresenting the terms of the benefits offered by or in connection with the MEWA or the financial condition of the MEWA or engaging in deceptive acts or omissions in connection with marketing or sales or fees charged to employers or employee organizations.

(3) **The conduct of a MEWA creates an immediate danger to the public safety or welfare** if the conduct of a MEWA or any person acting as an agent or employee of the MEWA impairs, or threatens to impair, a MEWA’s ability to pay claims or otherwise unreasonably increases the risk of nonpayment of benefits. Intent to create an immediate danger is not required for this criterion. Examples of such conduct include, but are not limited to, a systematic failure to properly process or pay benefit claims, including failure to establish and maintain a claims procedure that complies with the Secretary’s claims procedure regulations (29 CFR 2560.503–1 and 29 CFR 2590.715–2719), failure to establish or maintain a recordkeeping system that tracks the claims made, paid, or processed or the MEWA’s financial condition, a substantial failure to meet applicable disclosure, reporting, and other filing requirements, including the annual reporting and registration requirements under sections 101(g) and 104 of ERISA, failure to establish and implement a policy or method to determine that the MEWA is actuarially sound with appropriate reserves and adequate underwriting, failure to comply with a cease and desist order issued by a government agency or court, and failure to hold plan assets in trust.

(4) **The conduct of a MEWA is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury:**
(i) If the conduct of a MEWA, or of a person acting as an agent or employee of the MEWA, is having, or is reasonably expected to have, a significant and imminent negative effect on one or more of the following:

(A) An employee welfare benefit plan that is, or offers benefits in connection with, a MEWA;

(B) The sponsor of such plan or the employer or employee organization that makes payments for benefits provided by or in connection with a MEWA; or

(C) Plan participants and plan beneficiaries; and

(ii) If it is not reasonable to expect that such effect will be fully repaired or rectified.

Intent to cause injury is not required for this criterion. Examples of such conduct include, but are not limited to, conversion or concealment of property of the MEWA; improper disposal, transfer, or removal of funds or other property of the MEWA, including unreasonable compensation or payments to MEWA operators and service providers (e.g., brokers, marketers, and third party administrators); employment by the MEWA of a person prohibited from such employment pursuant to section 411 of ERISA, and embezzlement from the MEWA. For purposes of section 521 of ERISA, compensation that would be excessive under 26 CFR 1.162-7 will be considered unreasonable compensation or payments for purposes of this regulation. Depending upon the facts and circumstances, compensation may be unreasonable under this regulation even it is not excessive under 26 CFR 1.162-7.

(5) A MEWA is in a financially hazardous condition if:

(i) The Secretary has probable cause to believe that a MEWA:

(A) Is, or is in imminent danger of becoming, unable to pay benefit claims as they come due, or

(B) Has sustained, or is in imminent danger of sustaining, a significant loss of assets; or

(ii) A person responsible for management, control, or administration of the MEWA’s assets is the subject of a cease and desist order issued by the Secretary.

(6) A person, for purposes of this section, is an individual, partnership, corporation, employee welfare benefit plan, association, or other entity or organization.

(c) Temporary cease and desist order.

(1)(i) The Secretary may issue a temporary cease and desist order when the Secretary finds there is reasonable cause to believe that the conduct of a MEWA, or any person acting as an agent or employee of the MEWA, is—

(A) Fraudulent;

(B) Creates an immediate danger to the public safety or welfare; or

(C) Is causing or can be reasonably expected to cause significant, imminent, and irreparable public injury.

(ii) A single act or omission may be the basis for a temporary cease and desist order.

(2) A temporary cease and desist order, as the Secretary determines is necessary and appropriate to stop the conduct on which the order is based, and to protect the interests of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, may—

(i) Prohibit specific conduct or prohibit the transaction of any business of the MEWA;

(ii) Prohibit any person from taking specified actions, or exercising authority or control, concerning funds or property of a MEWA or of any employee benefit plan, regardless of whether such funds or property have been commingled with other funds or property; and

(iii) Bar any person either directly or indirectly, from providing management, administrative, or other services to any MEWA or to an employee benefit plan or trust.

(3) The Secretary may require documentation from the subject of the order verifying compliance.

(d) Effect of order on other remedies.

The issuance of a temporary or final cease and desist order shall not foreclose the Secretary from seeking additional remedies under ERISA.

(e) Administrative hearing.

(1) A temporary cease and desist order shall become a final order as to any MEWA or other person named in the order 30 days after such person receives notice of the order unless, within this period,
such person requests a hearing in accordance with the requirements of this paragraph (e).

(2) A person requesting a hearing must file a written request and an answer to the order showing cause why the order should be modified or set aside. The request and the answer must be filed in accordance with 29 CFR part 2571 and §18.4 of this title.

(3) A hearing shall be held expeditiously following the receipt of the request for a hearing by the Office of the Administrative Law Judges, unless the parties mutually consent, in writing, to a later date.

(4) The decision of the administrative law judge shall be issued expeditiously after the conclusion of the hearing.

(5) The Secretary must offer evidence supporting the findings made in issuing the order that there is reasonable cause to believe that the MEWA (or a person acting as an employee or agent of the MEWA) engaged in conduct specified in paragraph (c)(1) of this section.

(6) The person requesting the hearing has the burden to show that the order should be modified or set aside. To meet this burden such person must show by a preponderance of the evidence that the MEWA (or a person acting as an employee or agent of the MEWA) did not engage in conduct specified in paragraph (c)(1) of this section or must show that the requirements imposed by the order, are, in whole or part, arbitrary and capricious.

(7) Any temporary cease and desist order for which a hearing has been requested shall remain in effect and enforceable, pending completion of the administrative proceedings, unless stayed by the Secretary, an administrative law judge, or by a court.

(8) The Secretary may require that the hearing and all evidence be treated as confidential.

(f) Summary seizure order. (1) Subject to paragraphs (f)(2) and (3) of this section, the Secretary may issue a summary seizure order when the Secretary finds there is probable cause to believe that a MEWA is in a financially hazardous condition.

(2) Except as provided in paragraph (f)(3) of this section, the Secretary, before issuing a summary seizure order to remove assets and records from the control and management of the MEWA or any persons having custody or control of such assets or records, shall obtain judicial authorization from a federal court in the form of a warrant or other appropriate form of authorization and may at that time pursue other actions such as those set forth in paragraph (f)(5) of this section.

(3) If the Secretary reasonably believes that any delay in issuing the order is likely to result in the removal, dissipation, or concealment of plan assets or records, the Secretary may issue and serve a summary seizure order before seeking court authorization. Promptly following service of the order, the Secretary shall seek authorization from a federal court and may at that time pursue other actions such as those set forth in paragraph (f)(5) of this section.

(4) A summary seizure order may authorize the Secretary to take possession or control of all or part of the books, records, accounts, and property of the MEWA (including the premises in which the MEWA transacts its business) to protect the benefits of plan participants, plan beneficiaries, employers or employee organizations, or other members of the public, and to safeguard the assets of employee welfare benefit plans. The order may also direct any person having control and custody of the assets that are the subject of the order not to allow any transfer or disposition of such assets except upon the written direction of the Secretary, or of a receiver or independent fiduciary appointed by a court.

(5) In connection with or following the execution of a summary seizure order, the Secretary may—

(i) Secure court appointment of a receiver or independent fiduciary to perform any necessary functions of the MEWA;

(ii) Obtain court authorization for the Secretary, the receiver or independent fiduciary to take any other action to seize, secure, maintain, or preserve the availability of the MEWA’s assets; and

(iii) Obtain such other appropriate relief available under ERISA to protect
the interest of employee welfare benefit plan participants, plan beneficiaries, employers or employee organizations or other members of the public. Other appropriate equitable relief may include the liquidation and winding up of the MEWA’s affairs and, where applicable, the affairs of any person sponsoring the MEWA.

(g) **Effective date of orders.** Cease and desist and summary seizure orders are effective immediately upon issuance by the Secretary and shall remain effective, except to the extent and until any provision is modified or the order is set aside by the Secretary, an administrative law judge, or a court.

(h) **Service of orders.** (1) As soon as practicable after the issuance of a temporary or final cease and desist order and no later than five business days after issuance of a summary seizure order, the Secretary shall serve the order either:

(i) By delivering a copy to the person who is the subject of the order. If the person is a partnership, service may be made to any partner. If the person is a corporation, association, or other entity or organization, service may be made to any officer of such entity or any person designated for service of process under State law or the applicable plan document. If the person is an employee welfare benefit plan, service may be made to a trustee or administrator. A person’s attorney may accept service on behalf of such person;

(ii) By leaving a copy at the principal office, place of business, or residence of such person or attorney; or

(iii) By mailing a copy to the last known address of such person or attorney.

(2) If service is accomplished by certified mail, service is complete upon mailing. If service is done by regular mail, service is complete upon receipt by the addressee.

(3) Service of a temporary or final cease and desist order and of a summary seizure order shall include a statement of the Secretary’s findings giving rise to the order, and, where applicable, a copy of any warrant or other authorization by a court.

[78 FR 13805, Mar. 1, 2013]

§ 2560.521-2 Disclosure of order and proceedings.

(a) Notwithstanding §2560.521-1(e)(8), the Secretary shall make available to the public final cease and desist and summary seizure orders or modifications and terminations of such final orders.

(b) Except as prohibited by applicable law, and at his or her discretion, the Secretary may disclose the issuance of a temporary cease and desist order or summary seizure order and information and evidence of any proceedings and hearings related to an order, to any Federal, State, or foreign authorities responsible for enforcing laws that apply to MEWAs and parties associated with, or providing services to, MEWAs.

(c) The sharing of such documents, material, or other information and evidence under this section does not constitute a waiver of any applicable privilege or claim of confidentiality.

[78 FR 13805, Mar. 1, 2013]

§ 2560.521-3 Effect on other enforcement authority.

The Secretary’s authority under section 521 shall not be construed to limit the Secretary’s ability to exercise his or her enforcement or investigatory authority under any other provision of title I of ERISA, 29 U.S.C. 1001 et seq. The Secretary may, in his or her sole discretion, initiate court proceedings without using the procedures in this section.

[78 FR 13805, Mar. 1, 2013]

§ 2560.521-4 Cross-reference.

See 29 CFR 2571.1 through 2571.13 for procedural rules relating to administrative hearings under section 521 of ERISA.

[78 FR 13805, Mar. 1, 2013]
PART 2570—PROCEDURAL REGULATIONS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

Subpart A—Procedures for the Assessment of Civil Sanctions Under ERISA Section 502(i)

Sec. 2570.1 Scope of rules.
2570.2 Definitions.
2570.3 Service: Copies of documents and pleadings.
2570.4 Parties.
2570.5 Consequences of default.
2570.6 Consent order or settlement.
2570.7 Scope of discovery.
2570.8 Summary decision.
2570.9 Decision of the administrative law judge.
2570.10 Review by the Secretary.
2570.11 Scope of review.
2570.12 Procedures for review by the Secretary.

Subpart B—Procedures Governing the Filing and Processing of Prohibited Transaction Exemption Applications

2570.30 Scope of rules.
2570.31 Definitions.
2570.32 Persons who may apply for exemptions.
2570.33 Applications the Department will not ordinarily consider.
2570.34 Information to be included in every exemption application.
2570.35 Information to be included in applications for individual exemptions only.
2570.36 Where to file an application.
2570.37 Duty to amend and supplement exemption applications.
2570.38 Tentative denial letters.
2570.39 Opportunities to submit additional information.
2570.40 Conferences.
2570.41 Final denial letters.
2570.42 Notice of proposed exemption.
2570.43 Notification of interested persons by applicant.
2570.44 Withdrawal of exemption applications.
2570.45 Requests for reconsideration.
2570.46 Hearings in opposition to exemptions from restrictions on fiduciary self-dealing.
2570.47 Other hearings.
2570.48 Decision to grant exemptions.
2570.49 Limits on the effect of exemptions.
2570.50 Revocation or modification of exemptions.
2570.51 Public inspection and copies.

Subpart C—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(2)

2570.60 Scope of rules.
2570.61 Definitions.
2570.62 Service: Copies of documents and pleadings.
2570.63 Parties, how designated.
2570.64 Consequences of default.
2570.65 Consent order or settlement.
2570.66 Scope of discovery.
2570.67 Summary decision.
2570.68 Decision of the administrative law judge.
2570.69 Review by the Secretary.
2570.70 Scope of review.
2570.71 Procedures for review by the Secretary.

Subpart D—Procedure for the Assessment of Civil Penalties Under ERISA Section 502(l)

2570.80 Scope of rules.
2570.81 In general.
2570.82 Definitions.
2570.83 Assessment of civil penalty.
2570.84 Payment of civil penalty.
2570.85 Waiver or reduction of civil penalty.
2570.86 Reduction of penalty by other penalty assessments.
2570.87 Revision of assessment.
2570.88 Effective date.

Subpart E—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(5)

2570.90 Scope of Rules.
2570.91 Definitions.
2570.92 Service: Copies of documents and pleadings.
2570.93 Parties, how designated.
2570.94 Consequences of default.
2570.95 Consent order or settlement.
2570.96 Scope of discovery.
2570.97 Summary decision.
2570.98 Decision of the administrative law judge.
2570.99 Review by the Secretary.
2570.100 Scope of review.
2570.101 Procedures for review by the Secretary.

Subpart F—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(6)

2570.110 Scope of rules.
2570.111 Definitions.
2570.112 Service: Copies of documents and pleadings.
2570.113 Parties, how designated.
2570.114 Consequences of default.
§ 2570.1 Scope of rules.

The rules of practice set forth in this part are applicable to “prohibited transaction penalty proceedings” (as defined in §2570.2(o) of this part) under section 502(i) of the Employee Retirement Income Security Act of 1974. The rules of procedure for administrative hearings published by the Department’s Office of Administrative Law Judges at part 18 of this title will apply to matters arising under ERISA section 502(i) except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.2 Definitions.

For prohibited transaction penalty proceedings, this section shall apply in lieu of the definitions in §18.2 of this title:

(a) **Adjudicatory proceeding** means a judicial-type proceeding leading to the formulation of a final order;

(b) **Administrative law judge** means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) **Answer** is defined for these proceedings as set forth in §18.5(d)(2) of this title;

(d) **Commencement of proceeding** is the filing of an answer by the respondent;

(e) **Consent agreement** means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) **ERISA** means the Employee Retirement Income Security Act of 1974, as amended;

(g) **Final order** means the final decision or action of the Department of Labor concerning the assessment of a...
civil sanction under ERISA section 502(i) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, or the failure of a party to invoke the procedures for hearings or appeals under this title. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(b) Hearing means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) Notice means any document, however designated, issued by the Department of Labor which initiates an adjudicatory proceeding under ERISA section 502(i);

(j) Order means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(i);

(k) Party includes a person or agency named or admitted as a party to a proceeding;

(l) Person includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(m) Petition means a written request, made by a person or party, for some affirmative action;

(n) Pleading means the notice, the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(o) Prohibited transaction penalty proceeding means a proceeding relating to the assessment of the civil penalty provided for in section 502(i) of ERISA;

(p) Respondent means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(i);

(q) Secretary means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Employee Benefits Security), administrator, commissioner, appellate body, board, or other official;

(r) Solicitor means the Solicitor of Labor or his or her delegate.

§ 2570.3 Service: Copies of documents and pleadings.

For prohibited transaction penalty proceedings, this section shall apply in lieu of §18.3 of this title.

(a) General. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001-8002, or to the OALJ regional Office to which the proceedings may have been transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs or other documents shall be filed with the Office of Administrative Law Judges with a copy including any attachments to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 502(i) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents, except notices, shall be made by regular mail to the last known address.

(d) Service of notices. (1) Service of notices shall be made either:

(i) By delivering a copy to the individual, any partner, any officer of a corporation, or any attorney of record;

(ii) By leaving a copy at the principal office, place of business, or residence of such individual, partner, officer or attorney; or

(iii) By mailing a copy to the last known address of such individual, partner, officer or attorney.

(2) If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee.
(e) Form of pleadings. (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8 1/2 x 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopied, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.


§ 2570.4 Parties.

For prohibited transaction penalty proceedings, this section shall apply in lieu of §18.10 of this title.

(a) The term party wherever used in these rules shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil sanction is sought shall be designated as “respondent.” The Department shall be designated as the “complainant.”

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceeding and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner’s interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.5 Consequences of default.

For prohibited transaction penalty proceedings, this section shall apply in lieu of §18.5(b) of this title. Failure of the respondent to file an answer within the 30 day time period provided in §18.5 of this title shall be deemed to constitute a waiver of his right to appear and contest the allegations of the notice, and such failure shall be deemed
to be an admission of the facts as alleged in the notice for purposes of the prohibited transaction penalty proceeding. Such notice shall then become the final order of the Secretary, except that the administrative law judge may set aside a default entered under this provision where there is proof of defective notice.

§ 2570.6 Consent order or settlement.

For prohibited transaction penalty proceedings, the following shall apply in lieu of §18.9 of this title.

(a) General. At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such deferment and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) Content. Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and

(5) That the order and decision of the administrative law judge shall be final agency action.

(c) Submission. On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) Disposition. In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within thirty (30) days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) Settlement without consent of all parties. In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon
which a decision on the contested issues may reasonably be based;
(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.7 Scope of discovery.
For prohibited transaction penalty proceedings, this section shall apply in lieu of §18.14 of this title.
(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish “good cause” for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which “good cause” has been shown, as provided in this paragraph.
(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party’s representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon a showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the proceeding.

§ 2570.8 Summary decision.
For prohibited transaction penalty proceedings, this section shall apply in lieu of §18.41 of this title.
(a) No genuine issue of material fact. (1) Where no genuine issue of a material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§2570.10–2570.12 of this part, shall become a final order.
(2) A decision made under this paragraph shall include a statement of:
(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and
(ii) Any terms and conditions of the rule or order.
(3) A copy of any decision under this paragraph shall be served on each party.
(b) Hearings on issue of fact. Where a genuine question of material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.9 Decision of the administrative law judge.
For prohibited transaction penalty proceedings, this section shall apply in lieu of §18.57 of this title.
(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge’s discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and brief shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.
(b) Decision of the administrative law judge. Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall
include findings of fact and conclusions of law with reasons therefor upon each material issue of fact of law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for prohibited transaction penalty proceedings as set forth in this part, the penalty (if any) which may be included in the decision of the administrative law judge shall be limited to the sanction expressly provided for in section 502(1) of ERISA. It shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§2570.10 through 2570.12.

§ 2570.10 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him a copy of the entire record before the administrative law judge.

§ 2570.11 Scope of review.

The review of the Secretary shall not be a de novo proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.12 Procedures for review by the Secretary.

(a) Upon receipt of a notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart B—Procedures Governing the Filing and Processing of Prohibited Transaction Exemption Applications

SOURCE: 76 FR 66644, Oct. 27, 2011, unless otherwise noted.

§ 2570.30 Scope of rules.

(a) The rules of procedure set forth in this subpart apply to prohibited transaction exemptions issued by the Department under the authority of:

(1) Section 408(a) of the Employee Retirement Income Security Act of 1974 (ERISA);

(2) Section 4975(c)(2) of the Internal Revenue Code of 1986 (the Code);1 or


(b) Under these rules of procedure, the Department may conditionally or unconditionally exempt any fiduciary or transaction, or class of fiduciaries or transactions, from all or part of the restrictions imposed by section 406 of ERISA and the corresponding restrictions of the Code and FERSA. While administrative exemptions granted

1 Section 102 of Presidential Reorganization Plan No. 4 of 1978 (3 CFR part 332 (1978), reprinted in 5 U.S.C. app. at 672 (2006), and in 92 Stat. 3790 (1978)), effective December 31, 1978, generally transferred the authority of the Secretary of the Treasury to issue administrative exemptions under section 4975(c)(2) of the Code to the Department of Labor.
under these rules are ordinarily prospective in nature, an applicant may also obtain retroactive relief for past prohibited transactions if certain safeguards described in this subpart were in place at the time the transaction was consummated.

(c) These rules govern the filing and processing of applications for both individual and class exemptions that the Department may propose and grant pursuant to the authorities cited in paragraph (a) of this section. The Department may also propose and grant exemptions on its own motion, in which case the procedures relating to publication of notices, hearings, evaluation and public inspection of the administrative record, and modification or revocation of previously granted exemptions will apply.

(d) The issuance of an administrative exemption by the Department under these procedural rules does not relieve a fiduciary or other party in interest or disqualified person with respect to a plan from the obligation to comply with certain other provisions of ERISA, the Code, or FERSA, including any prohibited transaction provisions to which the exemption does not apply, and the general fiduciary responsibility provisions of ERISA which require, among other things, that a fiduciary discharge his or her duties respecting the plan solely in the interests of the participants and beneficiaries of the plan and in a prudent fashion; nor does it affect the requirement of section 401(a) of the Code that the plan must operate for the exclusive benefit of the employees of the employer maintaining the plan and their beneficiaries.

(e) The Department will not propose or issue exemptions upon oral request alone, nor will the Department grant exemptions orally. An applicant for an administrative exemption may request and receive oral advice from Department employees in preparing an exemption application. However, such advice does not constitute part of the administrative record and is not binding on the Department in its processing of an exemption application or in its examination or audit of a plan.

(f) The Department will generally treat any exemption application that is filed solely under section 408(a) of ERISA or solely under section 4975(c)(2) of the Code as an exemption request filed under both section 408(a) and section 4975(c)(2) if it relates to a transaction that would be prohibited both by ERISA and the corresponding provisions of the Code.

§ 2570.31 Definitions.

For purposes of these procedures, the following definitions apply:

(a) An affiliate of a person means—
   (1) Any person directly or indirectly through one or more intermediaries, controlling, controlled by, or under common control with the person. 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;
   (2) Any director of, relative of, or partner in, any such person;
   (3) Any corporation, partnership, trust, or unincorporated enterprise of which such person is an officer, director, or a 5 percent or more partner or owner; or
   (4) Any employee or officer of the person who—
      (i) Is highly compensated (as defined in section 4975(e)(2)(H) of the Code), or
      (ii) Has direct or indirect authority, responsibility, or control regarding the custody, management, or disposition of plan assets involved in the subject exemption transaction.

(b) A class exemption is an administrative exemption, granted under section 408(a) of ERISA, section 4975(c)(2) of the Code, and/or 5 U.S.C. 8417(c)(3), which applies to any transaction and party in interest within the class of transactions and parties in interest specified in the exemption when the conditions of the exemption are satisfied.

(c) Department means the U.S. Department of Labor and includes the Secretary of Labor or his or her delegate exercising authority with respect to prohibited transaction exemptions to which this subpart applies.

(d) Exemption transaction means the transaction or transactions for which an exemption is requested.

(e) An individual exemption is an administrative exemption, granted under
Employee Benefits Security Admin., Labor

§ 2570.31

section 408(a) of ERISA, section 4975(c)(2) of the Code, and/or 5 U.S.C. 8477(c)(3), which applies only to the specific parties in interest and transactions named or otherwise defined in the exemption.

(f) A party in interest means a person described in section 3(14) of ERISA or 5 U.S.C. 8477(a)(4) and includes a disqualified person, as defined in section 4975(e)(2) of the Code.

(g) Pooled fund means an account or fund for the collective investment of the assets of two or more unrelated plans, including (but not limited to) a pooled separate account maintained by an insurance company and a common or collective trust fund maintained by a bank or similar financial institution.

(h) A qualified appraisal report is any appraisal report that satisfies all of the requirements set forth in this subpart at §2570.34(c)(4).

(i) A qualified independent appraiser is any individual or entity with appropriate training, experience, and facilities to provide a qualified appraisal report on behalf of the plan regarding the particular asset or property appraised in the report, that is independent of and unrelated to any party in interest engaging in the exemption transaction and its affiliates; in general, the determination as to the independence of the appraiser is made by the Department on the basis of all relevant facts and circumstances. In making this determination, the Department generally will take into account the amount of both the appraiser’s revenues and projected revenues for the current federal income tax year (including amounts received for preparing the appraisal report) that will be derived from the party in interest or its affiliates relative to the appraiser’s revenues from all sources for the prior federal income tax year. Absent facts and circumstances demonstrating a lack of independence, the Department will operate according to the presumption that such appraiser will be independent if the revenues it receives or is projected to receive, within the current federal income tax year, from parties in interest (and their affiliates) to the transaction are not more than 2% of such appraiser’s annual revenues based upon its prior income tax year. Although the presumption does not apply when the aforementioned percentage exceeds 2%, an appraiser nonetheless may be considered independent based upon other facts and circumstances provided that it receives or is projected to receive revenues that are not more than 5% within the current federal income tax year from parties in interest (and their affiliates) to the transaction based upon its prior income tax year.

(j) A qualified independent fiduciary is any individual or entity with appropriate training, experience, and facilities to act on behalf of the plan regarding the exemption transaction in accordance with the fiduciary duties and responsibilities prescribed by ERISA, that is independent of and unrelated to any party in interest engaging in the exemption transaction and its affiliates; in general, the determination as to the independence of a fiduciary is made by the Department on the basis of all relevant facts and circumstances. In making this determination, the Department generally will take into account the amount of both the fiduciary’s revenues and projected revenues for the current federal income tax year (including amounts received for preparing fiduciary reports) that will be derived from the party in interest or its affiliates relative to the fiduciary’s revenues from all sources for the prior federal income tax year. Absent facts and circumstances demonstrating a lack of independence, the Department will operate according to the presumption that such fiduciary will be independent if the revenues it receives or is projected to receive, within the current federal income tax year, from parties in interest (and their affiliates) to the transaction are not more than 2% of such fiduciary’s annual revenues based upon its prior income tax year. Although the presumption does not apply when the aforementioned percentage exceeds 2%, a fiduciary nonetheless may be considered independent based upon other facts and circumstances provided that it receives or is projected to receive revenues that are not more than 5% within the current federal income tax year from parties in interest (and their affiliates) to the transaction based upon its prior income tax year.
§ 2570.32 Persons who may apply for exemptions.

(a) The Department will initiate exemption proceedings upon the application of:

(1) Any party in interest to a plan who is or may be a party to the exemption transaction;
(2) Any plan which is a party to the exemption transaction; or
(3) In the case of an application for an exemption covering a class of parties in interest or a class of transactions, in addition to any person described in paragraphs (a)(1) and (2) of this section, an association or organization representing parties in interest who may be parties to the exemption transaction.

(b) An application by or for a person described in paragraph (a) of this section, may be submitted by the applicant or by an authorized representative. An application submitted by a representative of the applicant must include proof of authority in the form of:

(1) A power of attorney; or
(2) A written certification from the applicant that the representative is authorized to file the application.

(c) If the authorized representative of an applicant submits an application for an exemption to the Department together with proof of authority to file the application as required by paragraph (b) of this section, the Department will direct all correspondence and inquiries concerning the application to the representative unless requested to do otherwise by the applicant.

§ 2570.33 Applications the Department will not ordinarily consider.

(a) The Department ordinarily will not consider:

(1) An application that fails to include all the information required by §§ 2570.34 and 2570.35 of this subpart or otherwise fails to conform to the requirements of these procedures; or
(2) An application involving a transaction or transactions which are the subject of an investigation for possible violations of part 1 or 4 of subtitle B of Title I of ERISA or section 8777 or 8778 of FERSA or an application involving a party in interest who is the subject of such an investigation or who is a defendant in an action by the Department or the Internal Revenue Service to enforce the above-mentioned provisions of ERISA or FERSA.

(b) An application for an individual exemption relating to a specific transaction or transactions ordinarily will not be considered if the Department has under consideration a class exemption relating to the same type of transaction or transactions. Notwithstanding the foregoing, the Department may consider such an application if the issuance of the final class exemption may not be imminent, and the Department determines that time constraints necessitate consideration of the transaction on an individual basis.

(c) The administrative record of an exemption application includes the initial exemption application and any supporting information provided by the applicant (as well as any comments and testimony received by the Department in connection with an application). If an applicant designates as confidential any information required by these regulations or requested by the Department, the Department will determine whether the information is material to the exemption determination. If it determines the information to be material, the Department will not process the application unless the applicant withdraws the claim of confidentiality.

(d) If for any reason the Department decides not to consider an exemption application, it will inform the applicant in writing of that decision and of the reasons therefore.

§ 2570.34 Information to be included in every exemption application.

(a) All applications for exemptions must contain the following information:

(1) The name(s) of the applicant(s);
(2) A detailed description of the exemption transaction including identification of all the parties in interest involved, a description of any larger integrated transaction of which the exemption transaction is a part, and a chronology of the events leading up to the transaction;
(3) The identity of any representatives for the affected plan(s) and parties in interest and what individuals or entities they represent;

(4) The reasons a plan would have for entering into the exemption transaction;

(5) The prohibited transaction provisions from which exemptive relief is requested and the reason why the transaction would violate each such provision;

(6) Whether the exemption transaction is customary for the industry or class involved;

(7) Whether the exemption transaction is or has been the subject of an investigation or enforcement action by the Department or by the Internal Revenue Service; and

(8) The hardship or economic loss, if any, which would result to the person or persons on behalf of whom the exemption is sought, to affected plans, and to their participants and beneficiaries from denial of the exemption.

(b) All applications for exemption must also contain the following:

(1) A statement explaining why the requested exemption would be—

(i) Administratively feasible;

(ii) In the interests of affected plans and their participants and beneficiaries; and

(iii) Protective of the rights of participants and beneficiaries of affected plans.

(2) With respect to the notification of interested persons required by §2570.43:

(i) A description of the interested persons to whom the applicant intends to provide notice;

(ii) The manner in which the applicant will provide such notice; and

(iii) An estimate of the time the applicant will need to furnish notice to all interested persons following publication of a notice of the proposed exemption in the Federal Register.

(3) If an advisory opinion has been requested by any party to the exemption transaction from the Department with respect to any issue relating to the exemption transaction—

(i) A copy of the letter concluding the Department’s action on the advisory opinion request; or

(ii) If the Department has not yet concluded its action on the request:

(A) A copy of the request or the date on which it was submitted together with the Department’s correspondence control number as indicated in the acknowledgment letter; and

(B) An explanation of the effect of the issuance of an advisory opinion upon the exemption transaction.

(4) If the application is to be signed by anyone other than an individual party in interest seeking exemptive relief on his or her own behalf, a statement which—

(i) Identifies the individual signing the application and his or her position or title; and

(ii) Explains briefly the basis of his or her familiarity with the matters discussed in the application.

(5)(i) A declaration in the following form:

Under penalty of perjury, I declare that I am familiar with the matters discussed in this application and, to the best of my knowledge and belief, the representations made in this application are true and correct.

(ii) This declaration must be dated and signed by:

(A) The applicant, in its individual capacity, in the case of an individual party in interest seeking exemptive relief on his or her own behalf;

(B) A corporate officer or partner where the applicant is a corporation or partnership;

(C) A designated officer or official where the applicant is an association, organization or other unincorporated enterprise; or

(D) The plan fiduciary that has the authority, responsibility, and control with respect to the exemption transaction where the applicant is a plan.

(c) Specialized statements, as applicable, from a qualified independent appraiser acting solely on behalf of the plan, such as appraisal reports or analyses of market conditions, submitted to support an application for exemption must be accompanied by a statement of consent from such appraiser acknowledging that the statement is being submitted to the Department as part of an application for exemption. Such statements must also contain the following written information:

(1) A copy of the qualified independent appraiser’s engagement letter
with the plan describing the specific duties the appraiser shall undertake;

(2) A summary of the qualified independent appraiser’s qualifications to serve in such capacity;

(3) A detailed description of any relationship that the qualified independent appraiser has had or may have with any party in interest engaging in the transaction with the plan, or its affiliates, that may influence the appraiser;

(4) A written appraisal report prepared by the qualified independent appraiser, acting solely on behalf of the plan, rather than, for example, on behalf of the plan sponsor, which satisfies the following requirements:
   (i) The report must describe the method(s) used in determining the fair market value of the subject asset(s) and an explanation of why such method best reflects the fair market value of the asset(s);
   (ii) The report must take into account any special benefit that the party in interest or its affiliate(s) may derive from control of the asset(s), such as from owning an adjacent parcel of real property or gaining voting control over a company; and
   (iii) The report must be current and not more than one year old from the date of the transaction, and there must be a written update by the qualified independent appraiser affirming the accuracy of the appraisal as of the date of the transaction. If the appraisal report is a year old or more, a new appraisal shall be submitted to the Department by the applicant.

(5) If the subject of the appraisal report is real property, the qualified independent appraiser shall submit a written representation that he or she is a member of a professional organization of appraisers that can sanction its members for misconduct;

(6) If the subject of the appraisal report is an asset other than real property, the qualified independent appraiser shall submit a written representation describing the appraiser’s prior experience in valuing assets of the same type; and

(7) The qualified independent appraiser shall submit a written representation disclosing the percentage of its current revenue that is derived from any party in interest involved in the transaction or its affiliates; in general, such percentage shall be computed by comparing, in fractional form:
   (i) The amount of the appraiser’s projected revenues from the current federal income tax year (including amounts received from preparing the appraisal report) that will be derived from the party in interest or its affiliates (expressed as a numerator); and
   (ii) The appraiser’s revenues from all sources for the prior federal income tax year (expressed as a denominator).

(d) For those exemption transactions requiring the retention of a qualified independent fiduciary to represent the interests of the plan, a statement must be submitted by such fiduciary that contains the following written information:

(1) A signed and dated declaration under penalty of perjury that, to the best of the qualified independent fiduciary’s knowledge and belief, all of the representations made in such statement are true and correct;

(2) A copy of the qualified independent fiduciary’s engagement letter with the plan describing the fiduciary’s specific duties;

(3) An explanation for the conclusion that the fiduciary is a qualified independent fiduciary, which also must include a summary of that person’s qualifications to serve in such capacity, as well as a description of any prior experience by that person or other demonstrated characteristics of the fiduciary (such as special areas of expertise) that render that person or entity suitable to perform its duties on behalf of the plan with respect to the exemption transaction;

(4) A detailed description of any relationship that the qualified independent fiduciary has had or may have with the party in interest engaging in the transaction with the plan or its affiliates;

(5) An acknowledgement by the qualified independent fiduciary that it understands its duties and responsibilities under ERISA in acting as a fiduciary on behalf of the plan rather than, for example, acting on behalf of the plan sponsor;
(6) The qualified independent fiduciary’s opinion on whether the proposed transaction would be in the interests of the plan and of its participants and beneficiaries, and protective of the rights of participants and beneficiaries of such plan, along with a statement of the reasons on which the opinion is based;

(7) Where the proposed transaction is continuing in nature, a declaration by the qualified independent fiduciary that it is authorized to take all appropriate actions to safeguard the interests of the plan, and shall, during the pendency of the transaction:

(i) Monitor the transaction on behalf of the plan on a continuing basis;

(ii) Ensure that the transaction remains in the interests of the plan and, if not, take any appropriate actions available under the particular circumstances; and

(iii) Enforce compliance with all conditions and obligations imposed on any party dealing with the plan with respect to the transaction; and

(8) The qualified independent fiduciary shall submit a written representation disclosing the percentage of such fiduciary’s current revenue that is derived from any party in interest or its affiliates; in general, such percentage shall be computed by comparing, in fractional form:

(i) The amount of the fiduciary’s projected revenues from the current federal income tax year that will be derived from the party in interest or its affiliates (expressed as a numerator); and

(ii) The fiduciary’s revenues from all sources (excluding fixed, non-discretionary retirement income) for the prior federal income tax year (expressed as a denominator).

(e) Specialized statements, as applicable, from other third-party experts, including but not limited to economists or market specialists, submitted on behalf of the plan to support an application for exemption must be accompanied by a statement of consent from such expert acknowledging that the statement prepared on behalf of the plan is being submitted to the Department as part of an application for exemption. Such statements must also contain the following written information:

(1) A copy of the expert’s engagement letter with the plan describing the specific duties the expert will undertake;

(2) A summary of the expert’s qualifications to serve in such capacity; and

(3) A detailed description of any relationship that the expert has had or may have with any party in interest engaging in the transaction with the plan, or its affiliates, that may influence the actions of the expert.

(f) An application for exemption may also include a draft of the requested exemption which describes the transaction and parties in interest for which exemptive relief is sought and the specific conditions under which the exemption would apply.

§ 2570.35 Information to be included in applications for individual exemptions only.

(a) Except as provided in paragraph (c) of this section, every application for an individual exemption must include, in addition to the information specified in §2570.34 of this subpart, the following information:

(1) The name, address, telephone number, and type of plan or plans to which the requested exemption applies;

(2) The Employer Identification Number (EIN) and the plan number (PN) used by such plan or plans in all reporting and disclosure required by the Department;

(3) Whether any plan or trust affected by the requested exemption has ever been found by the Department, the Internal Revenue Service, or by a court to have violated the exclusive benefit rule of section 401(a) of the Code, section 4975(c)(1) of the Code, section 406 or 407(a) of ERISA, or 5 U.S.C. 8477(c)(3), including a description of the circumstances surrounding such violation;

(4) Whether any relief under section 408(a) of ERISA, section 4975(c)(2) of the Code, or 5 U.S.C. 8477(c)(3) has been requested by, or provided to, the applicant or any of the parties on behalf of whom the exemption is sought and, if so, the exemption application number or the prohibited transaction exemption number;
§2570.35

(5) Whether the applicant or any of the parties in interest involved in the exemption transaction is currently, or has been within the last five years, a defendant in any lawsuit or criminal action concerning such person's conduct as a fiduciary or party in interest with respect to any plan (other than a lawsuit with respect to a routine claim for benefits), and a description of the circumstances of such lawsuit or criminal action;

(6) Whether the applicant (including any person described in §2570.34(b)(5)(ii)) or any of the parties in interest involved in the exemption transaction has, within the last 13 years, been either convicted or released from imprisonment, whichever is later, as a result of: any felony involving abuse or misuse of such person's position or employment with an employee benefit plan or a labor organization; any felony arising out of the conduct of the business of a broker, dealer, investment adviser, bank, insurance company or fiduciary; income tax evasion; any felony involving the larceny, theft, robbery, extortion, forgery, counterfeiting, fraudulent concealment, embezzlement, fraudulent conversion, or misappropriation of funds or securities; conspiracy or attempt to commit any such crimes or a crime of which any of the foregoing crimes is an element; or any other crime described in section 411 of ERISA, and a description of the circumstances of any such conviction. For purposes of this section, a person shall be deemed to have been "convicted" from the date of the judgment of the trial court, regardless of whether that judgment remains under appeal;

(7) Whether, within the last five years, any plan affected by the exemption transaction, or any party in interest involved in the exemption transaction, has been under investigation or examination by, or has been engaged in litigation or a continuing controversy with, the Department, the Internal Revenue Service, the Justice Department, the Pension Benefit Guaranty Corporation, or the Federal Retirement Thrift Investment Board involving compliance with provisions of ERISA, provisions of the Code relating to employee benefit plans, or provisions of FERSA relating to the Federal Thrift Savings Fund. If so, the applicant must provide a brief statement describing the investigation, examination, litigation or controversy. The Department reserves the right to require the production of additional information or documentation concerning any of the above matters. In this regard, a denial of the exemption application will result from a failure to provide additional information requested by the Department.

(8) Whether any plan affected by the requested exemption has experienced a reportable event under section 4043 of ERISA, and, if so, a description of the circumstances of any such reportable event;

(9) Whether a notice of intent to terminate has been filed under section 4041 of ERISA respecting any plan affected by the requested exemption, and, if so, a description of the circumstances for the issuance of such notice;

(10) Names, addresses, and taxpayer identifying numbers of all parties in interest involved in the subject transaction:

(11) The estimated number of participants and beneficiaries in each plan affected by the requested exemption as of the date of the application;

(12) The percentage of the fair market value of the total assets of each affected plan that is involved in the exemption transaction;

(13) Whether the exemption transaction has been consummated or will be consummated only if the exemption is granted;

(14) If the exemption transaction has already been consummated:

(i) The circumstances which resulted in plan fiduciaries causing the plan(s) to engage in the transaction before obtaining an exemption from the Department;

(ii) Whether the transaction has been terminated;

(iii) Whether the transaction has been corrected as defined in Code section 4975(f)(5);

(iv) Whether Form 5330, Return of Excise Taxes Related to Employee Benefit Plans, has been filed with the Internal Revenue Service with respect to the transaction; and
(v) Whether any excise taxes due under section 4975(a) and (b) of the Code, or any civil penalties due under section 502(l) or (l) of ERISA by reason of the transaction have been paid. If so, the applicant should submit documentation (e.g., a canceled check) demonstrating that the excise taxes or civil penalties were paid.

(15) The name of every person who has investment discretion over any plan assets involved in the exemption transaction and the relationship of each such person to the parties in interest involved in the exemption transaction and the affiliates of such parties in interest;

(16) Whether or not the assets of the affected plan(s) are invested in loans to any party in interest involved in the exemption transaction, in property leased to any such party in interest, or in securities issued by any such party in interest, and, if such investments exist, a statement for each of these three types of investments which indicates:

(i) The type of investment to which the statement pertains;
(ii) The aggregate fair market value of all investments of this type as reflected in the plan’s most recent annual report;
(iii) The approximate percentage of the fair market value of the plan’s total assets as shown in such annual report that is represented by all investments of this type; and
(iv) The statutory or administrative exemption covering these investments, if any.

(17) The approximate aggregate fair market value of the total assets of each affected plan;

(18) The person(s) who will bear the costs of the exemption application and of notifying interested persons; and

(19) Whether an independent fiduciary is or will be involved in the exemption transaction and, if so, the names of the persons who will bear the cost of the fee payable to such fiduciary.

(b) Each application for an individual exemption must also include:

(1) True copies of all contracts, deeds, agreements, and instruments, as well as relevant portions of plan documents, trust agreements, and any other documents bearing on the exemption transaction;

(2) A discussion of the facts relevant to the exemption transaction that are reflected in these documents and an analysis of their bearing on the requested exemption;

(3) A copy of the most recent financial statements of each plan affected by the requested exemption; and

(4) A net worth statement with respect to any party in interest that is providing a personal guarantee with respect to the exemption transaction.

(c) Special rule for applications for individual exemption involving pooled funds:

(1) The information required by paragraphs (a)(8) through (12) of this section is not required to be furnished in an application for individual exemption involving one or more pooled funds;

(2) The information required by paragraphs (a)(1) through (7) and (a)(13) through (19) of this section and by paragraphs (b)(1) through (3) of this section must be furnished in reference to the pooled fund, rather than to the plans participating therein. (For purposes of this paragraph, the information required by paragraph (a)(16) of this section relates solely to other pooled fund transactions with, and investments in, parties in interest involved in the exemption transaction which are also sponsors of plans which invest in the pooled fund.);

(3) The following information must also be furnished—

(i) The estimated number of plans that are participating (or will participate) in the pooled fund; and

(ii) The minimum and maximum limits imposed by the pooled fund (if any) on the portion of the total assets of each plan that may be invested in the pooled fund.

(4) Additional requirements for applications for individual exemption involving pooled funds in which certain plans participate.

(i) This paragraph applies to any application for an individual exemption involving one or more pooled funds in which any plan participating therein—

(A) Invests an amount which exceeds 20% of the total assets of the pooled fund, or
(B) Covers employees of:

(1) The party sponsoring or maintaining the pooled fund, or any affiliate of such party, or

(2) Any fiduciary with investment discretion over the pooled fund’s assets, or any affiliate of such fiduciary.

(ii) The exemption application must include, with respect to each plan described in paragraph (c)(4)(i) of this section, the information required by paragraphs (a)(1) through (3), (a)(5) through (7), (a)(10), (a)(12) through (16), and (a)(18) and (19), of this section. The information required by this paragraph must be furnished in reference to the plan’s investment in the pooled fund (e.g., the names, addresses and taxpayer identifying numbers of all fiduciaries responsible for the plan’s investment in the pooled fund (§2570.35(a)(10)), the percentage of the assets of the plan invested in the pooled fund (§2570.35(a)(12)), whether the plan’s investment in the pooled fund has been consummated or will be consummated only if the exemption is granted (§2570.35(a)(13)), etc.).

(iii) The information required by paragraph (c)(4) of this section is in addition to the information required by paragraphs (c)(2) and (3) of this section relating to information furnished by reference to the pooled fund.

(5) The special rule and the additional requirements described in paragraphs (c)(1) through (4) of this section do not apply to an individual exemption request solely for the investment by a plan in a pooled fund. Such an application must provide the information required by paragraphs (a) and (b) of this section.

(d) Retroactive exemptions:

(1) Generally, the Department will favorably consider requests for retroactive relief, in all exemption applications, only where the safeguards necessary for the grant of a prospective exemption were in place at the time at which the parties entered into the transaction. An applicant for a retroactive exemption must have acted in good faith by taking reasonable and appropriate steps to protect the plan from abuse and unnecessary risk at the time of the transaction.

(2) Among the factors that the Department would take into account in making a finding that an applicant acted in good faith include the following:

(i) The participation of an independent fiduciary acting on behalf of the plan who is qualified to negotiate, approve and monitor the transaction;

(ii) The existence of a contemporaneous appraisal by a qualified independent appraiser or reference to an objective third party source, such as a stock or bond index;

(iii) The existence of a bidding process or evidence of comparable fair market transactions with unrelated third parties;

(iv) That the applicant has submitted an accurate and complete application for exemption containing documentation of all necessary and relevant facts and representations upon which the applicant relied. In this regard, additional weight will be given to facts and representations which are prepared and certified by a source independent of the applicant;

(v) That the applicant has submitted evidence that the plan fiduciary did not engage in an act or transaction knowing that such act or transaction was prohibited under section 406 of ERISA and/or section 4975 of the Code. In this regard, the Department will accord appropriate weight to the submission of a contemporaneous, reasoned legal opinion of counsel, upon which the plan fiduciary relied in good faith before entering the act or transaction;

(vi) That the applicant has submitted a statement of the circumstances which prompted the submission of the application for exemption and the steps taken by the applicant with regard to the transaction upon discovery of the violation;

(vii) That the applicant has submitted a statement, prepared and certified by an independent person familiar with the types of transactions for which relief is requested, demonstrating that the terms and conditions of the transaction (including, in the case of an investment, the return in fact realized by the plan) were at least as favorable to the plan as that obtainable in a similar transaction with an unrelated party; and

(viii) Such other undertakings and assurances with respect to the plan and
its participants that may be offered by
the applicant which are relevant to the
criteria under section 408(a) of ERISA
and section 4975(c)(2) of the Code.

(3) The Department, as a general
matter, will not favorably consider re-
quests for retroactive exemptions
where transactions or conduct with re-
spect to which an exemption is re-
quested resulted in a loss to the plan.
In addition, the Department will not
favorably consider requests for exemp-
tions where the transactions are incon-
sistent with the general fiduciary re-
sponsibility provisions of sections 403
or 404 of ERISA or the exclusive benefit
requirements of section 401(a) of the
Code.

§ 2570.36 Where to file an application.

The Department's prohibited trans-
action exemption program is adminis-
tered by the Employee Benefits Secu-
ritv Administration (EBSA). Any ex-
emption application governed by these
procedures may be mailed via first-
class mail to: Employee Benefits Secu-
ritv Administration, Office of Exemp-
tion Determinations, U.S. Department
of Labor, Room N–5700, 200 Constitu-
tion Avenue NW., Washington, DC
20210. Alternatively, applications may
be emailed to the Department at
e-OED@dol.gov or transmitted via fac-
simile at (202) 219–0204. Notwith-
standing the foregoing methods of
transmission, applicants are also re-
quired to submit one paper copy of the
exemption application for the Depart-
mant’s file.

§ 2570.37 Duty to amend and supple-
ment exemption applications.

(a) While an exemption application is
pending final action with the Depart-
mant, an applicant must promptly no-
tify the Department in writing if he or
she discovers that any material fact or
representation contained in the appli-
cation or in any documents or testi-
mony provided in support of the appli-
cation is inaccurate, if any such fact or
representation changes during this pe-
riod, or if, during the pendency of the
application, anything occurs that may
affect the continuing accuracy of any
such fact or representation. In addi-
tion, an applicant must promptly no-
tify the Department in writing if it
learns that a material fact or represen-
tation has been omitted from the ex-
emption application.

(b) If, at any time during the pend-
ency of an exemption application, the
applicant or any other party in inter-
est who would participate in the ex-
emption transaction becomes the sub-
ject of an investigation or enforcement
action by the Department, the Internal
Revenue Service, the Justice Depart-
ment, the Pension Benefit Guaranty
Corporation, or the Federal Retirement
Thrift Investment Board involving
compliance with provisions of ERISA,
provisions of the Code relating to em-
ployee benefit plans, or provisions of
FERSA relating to the Federal Thrift
Savings Fund, the applicant must
promptly notify the Department.

(c) The Department may require an
applicant to provide documentation it
considers necessary to verify any state-
ments contained in the application or
in supporting materials or documents.

§ 2570.38 Tentative denial letters.

(a) If, after reviewing an exemption
file, the Department tentatively con-
cludes that it will not propose or grant
the exemption, it will notify the appli-
cant in writing. At the same time, the
Department will provide a brief state-
ment of the reasons for its tentative
denial.

(b) An applicant will have 20 days
from the date of a tentative denial let-
ter to request a conference under
§2570.40 of this subpart and/or to notify
the Department of its intent to submit
additional information under §2570.39
of this subpart. If the Department does
not receive a request for a conference
or a notification of intent to submit
additional information within that
time, it will issue a final denial letter
pursuant to §2570.41.

(c) The Department need not issue a
tentative denial letter to an applicant
before issuing a final denial letter
where the Department has conducted a
hearing on the exemption pursuant to
either §2570.46 or §2570.47.
§ 2570.39 Opportunities to submit additional information.

(a) An applicant may notify the Department of its intent to submit additional information supporting an exemption application either by telephone or by letter sent to the address furnished in the applicant's tentative denial letter, or electronically to the email address provided in the tentative denial letter. At the same time, the applicant should indicate generally the type of information that will be submitted.

(b) The additional information an applicant intends to provide in support of the application must be in writing and be received by the Department within 40 days from the date of the tentative denial letter. All such information must be accompanied by a declaration under penalty of perjury attesting to the truth and correctness of the information provided, which is dated and signed by a person qualified under § 2570.34(b)(5) of this subpart to sign such a declaration.

(c) If, for reasons beyond its control, an applicant is unable to submit all the additional information he or she intends to provide in support of his application within the 40-day period described in paragraph (b) of this section, he or she may request an extension of time to furnish the information. Such requests must be made before the expiration of the 40-day period and will be granted only in unusual circumstances and for a limited period as determined, respectively, by the Department in its sole discretion.

(d) If an applicant is unable to submit all of the additional information he or she intends to provide in support of his application within the 40-day period described in paragraph (b) of this section, or within any additional period granted pursuant to paragraph (c) of this section;

(2) The applicant did not request a conference pursuant to § 2570.38(b) of this subpart; and

(3) The applicant has not withdrawn the application as permitted by paragraph (d) of this section.

§ 2570.40 Conferences.

(a) Any conference between the Department and an applicant pertaining to a requested exemption will be held in Washington, DC, except that a telephone conference will be held at the applicant's request.

(b) An applicant is entitled to only one conference with respect to any exemption application. An applicant will not be entitled to a conference, however, where the Department has held a hearing on the exemption under either § 2570.46 or § 2570.47 of this subpart.

(c) Insofar as possible, conferences will be scheduled as joint conferences with all applicants present where:

(1) More than one applicant has requested an exemption with respect to the same or similar types of transactions;

(2) The Department is considering the applications together as a request for a class exemption;

(3) The Department contemplates not granting the exemption; and

(4) More than one applicant has requested a conference.

(d) In instances where the applicant has requested a conference pursuant to § 2570.38(b) and also has submitted additional information pursuant to § 2570.39, the Department will schedule a conference under this section for a date and time that occurs within 20 days after the date on which the Department has provided either oral or written notification to the applicant that, after reviewing the additional information, it is still not prepared to propose the requested exemption. If, for reasons beyond its control, the applicant cannot attend a conference within the 20-day limit described in this paragraph, the applicant may request an extension of time for the scheduling of a conference, provided
that such request is made before the expiration of the 20-day limit. The Department will only grant such an extension in unusual circumstances and for a brief period as determined, respectively, by the Department in its sole discretion.

(e) In instances where the applicant has requested a conference pursuant to §2570.38(b) but has not expressed an intent to submit additional information in support of the exemption application as provided in §2570.39, the Department will schedule a conference under this section for a date and time that occurs within 40 days after the date of the issuance of the tentative denial letter described in §2570.38(a). If, for reasons beyond its control, the applicant cannot attend a conference within the 40-day limit described in this paragraph, the applicant may request an extension of time for the scheduling of a conference, provided that such request is made before the expiration of the 40-day limit. The Department will only grant such an extension in unusual circumstances and for a brief period as determined, respectively, by the Department in its sole discretion.

(f) In instances where the applicant has requested a conference pursuant to §2570.38(b) of this subpart, has notified the Department of its intent to submit additional information pursuant to §2570.39, and has failed to furnish such information within 40 days from the date of the tentative denial letter, the Department will schedule a conference under this section for a date and time that occurs within 60 days after the date of the issuance of the tentative denial letter described in §2570.38(a). If, for reasons beyond its control, the applicant cannot attend a conference within the 60-day limit described in this paragraph, the applicant may request an extension of time for the scheduling of a conference, provided that such request is made before the expiration of the 60-day limit. The Department will only grant such an extension in unusual circumstances and for a brief period as determined, respectively, by the Department in its sole discretion.

(g) If the applicant fails to either timely schedule or appear for a conference agreed to by the Department pursuant to this section, the applicant will be deemed to have waived its right to a conference.

(h) Within 20 days after the date of any conference held under this section, the applicant may submit to the Department (electronically or in paper form) any additional written data, arguments, or precedents discussed at the conference but not previously or adequately presented in writing. If, for reasons beyond its control, the applicant is unable to submit the additional information within this 20-day limit, the applicant may request an extension of time to furnish the information, provided that such request is made before the expiration of the 20-day limit described in this paragraph. The Department will only grant such an extension in unusual circumstances and for a brief period as determined, respectively, by the Department in its sole discretion.

§2570.41 Final denial letters.

The Department will issue a final denial letter denying a requested exemption where:

(a) The conditions for issuing a final denial letter specified in §2570.38(b) or §2570.38(e) of this subpart are satisfied;

(b) After issuing a tentative denial letter under §2570.38 of this subpart and considering the entire record in the case, including all written information submitted pursuant to §§2570.39 and 2570.40 of this subpart, the Department decides not to propose an exemption or to withdraw an exemption already proposed; or

(c) After proposing an exemption and conducting a hearing on the exemption under either §2570.46 or §2570.47 of this subpart and after considering the entire record in the case, including the record of the hearing, the Department decides to withdraw the proposed exemption.

§2570.42 Notice of proposed exemption.

If the Department tentatively decides that an administrative exemption is warranted, it will publish a notice of a proposed exemption in the Federal Register. In addition to providing notice of the pendency of the exemption before the Department, the notice will:
§ 2570.43 Notification of interested persons by applicant.

(a) If a notice of proposed exemption is published in the Federal Register in accordance with § 2570.42 of this subpart, the applicant must notify interested persons of the pendency of the exemption in the manner and within the time period specified in the application. If the Department determines that this notification would be inadequate, the applicant must obtain the Department’s consent as to the manner and time period of providing the notice to interested persons. Any such notification must include:

(1) A copy of the notice of proposed exemption as published in the Federal Register; and

(2) A supplemental statement in the following form:

You are hereby notified that the United States Department of Labor is considering granting an exemption from the prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, or the Federal Employees’ Retirement System Act of 1986. The exemption under consideration is summarized in the enclosed [Summary of Proposed Exemption, and described in greater detail in the accompanying] Notice of Proposed Exemption. As a person who may be affected by this exemption, you have the right to comment on the proposed exemption by [date]. [If you may be adversely affected by the grant of the exemption, you also have the right to request a hearing on the exemption by [date].]

All comments and/or requests for a hearing should be addressed to the Office of Exemption Determinations, Employee Benefits Security Administration, Room N–5700, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, ATTENTION: Application No. [Exemption Number]. Comments and hearing requests may also be transmitted to the Department electronically at eoe@dol.gov or at http://www.regulations.gov (follow instructions for submission), and should prominently reference the application number listed above. In addition, comments and hearing requests may be transmitted to the Department via facsimile at (202) 219–0204. Individuals submitting comments or requests for a hearing on this matter are advised not to disclose sensitive personal data, such as social security numbers.

The Department will make no final decision on the proposed exemption until it reviews the comments received in response to the enclosed notice. If the Department decides to hold a hearing on the exemption request before making its final decision, you will be notified of the time and place of the hearing.

(b) The method used by an applicant to furnish notice to interested persons must be reasonably calculated to ensure that interested persons actually receive the notice. In all cases, personal delivery and delivery by first-class mail will be considered reasonable methods of furnishing notice. If the applicant elects to furnish notice electronically, he or she must provide

\[\text{[The applicant will write in this space the date of the last day of the time period specified in the notice of proposed exemption.]}\]

\[\text{[To be added in the case of an exemption that provides relief from section 406(b) of ERISA or corresponding sections of the Code or FERSA.]}\]

\[\text{[The applicant will fill in the room number of the Office of Exemption Determinations. As of the date of this final regulation, the room number of the Office of Exemption Determinations is N–5700.]}\]

\[\text{[The applicant will fill in the exemption application number, which is stated in the notice of proposed exemption, as well as in all correspondence from the Department to the applicant regarding the application.]}\]
§ 2570.44 Withdrawal of exemption applications.

(a) An applicant may withdraw an application for an exemption at any time by oral or written (including electronic) notice to the Department. A withdrawn application generally shall not prejudice any subsequent applications for an exemption submitted by an applicant.

(b) Upon receiving an applicant's notice of withdrawal regarding an application for an individual exemption, the Department will confirm by letter the applicant's withdrawal of the application and will terminate all proceedings relating to the application. If a notice of proposed exemption has been published in the Federal Register, the Department will publish a notice withdrawing the proposed exemption.

(c) Upon receiving an applicant's notice of withdrawal regarding an application for a class exemption or for an individual exemption that is being considered with other applications as a request for a class exemption, the Department will inform any other applicants for the exemption of the withdrawal. The Department will continue to process other applications for the same exemption. If all applicants for a particular class exemption withdraw their applications, the Department may either terminate all proceedings relating to the exemption or propose the exemption on its own motion.

(d) If, following the withdrawal of an exemption application, an applicant decides to reapply for the same exemption, he or she may contact the Department in writing (including electronically) to request that the application be reinstated. The applicant should refer to the application number assigned to the original application. If, at the time the original application was withdrawn, any additional information to be submitted to the Department under §2570.39 was outstanding, that information must accompany the request for reinstatement of the application. However, the applicant need not resubmit information previously furnished to the Department in connection with a withdrawn application unless reinstatement of the application is requested more than two years after the date of its withdrawal.

§ 2570.44. Withdrawal of exemption applications.

(c) After furnishing the notification described in paragraph (a) of this section, an applicant must provide the Department with a written statement confirming that notice was furnished in accordance with the foregoing requirements of this section. This statement must be accompanied by a declaration under penalty of perjury attesting to the truth of the information provided in the statement and signed by a person qualified under §2570.34(b)(5) of this subpart to sign such a declaration. No exemption will be granted until such a statement and its accompanying declaration have been furnished to the Department.

(d) In addition to the provision of notification required by paragraph (a) of this section, the Department, in its discretion, may also require an applicant to furnish interested persons with a brief summary of the proposed exemption (Summary of Proposed Exemption), written in a manner calculated to be understood by the average recipient, which objectively describes:

(1) The exemption transaction and the parties in interest thereto;

(2) Why such transaction would violate the prohibited transaction provisions of ERISA, the Code, and/or FERSA from which relief is sought;

(3) The reasons why the plan seeks to engage in the transaction; and

(4) The conditions and safeguards proposed to protect the plan and its participants and beneficiaries from potential abuse or unnecessary risk of loss in the event the Department grants the exemption.

(e) Applicants who are required to provide interested persons with the Summary of Proposed Exemption described in paragraph (d) of this section shall furnish the Department with a copy of such summary for review and approval prior to its distribution to interested persons. Such applicants shall also provide confirmation to the Department that the Summary of Proposed Exemption was furnished to interested persons as part of the written statement and declaration required of exemption applicants by paragraph (c) of this section.
(e) Any request for reinstatement of a withdrawn application submitted, in accordance with paragraph (d) of this section, will be granted by the Department, and the Department will take whatever steps remained at the time the application was withdrawn to process the application.

§ 2570.45 Requests for reconsideration.

(a) The Department will entertain one request for reconsideration of an exemption application that has been finally denied pursuant to §2570.41 if the applicant presents in support of the application significant new facts or arguments, which, for good reason, could not have been submitted for the Department’s consideration during its initial review of the exemption application.

(b) A request for reconsideration of a previously denied application must be made within 180 days after the issuance of the final denial letter and must be accompanied by a copy of the Department’s final letter denying the exemption and a statement setting forth the new information and/or arguments that provide the basis for reconsideration.

(c) A request for reconsideration must also be accompanied by a declaration under penalty of perjury attesting to the truth of the new information provided, which is signed by a person qualified under §2570.34(b)(5) to sign such a declaration.

(d) If, after reviewing a request for reconsideration, the Department decides that the facts and arguments presented do not warrant reversal of its original decision to deny the exemption, it will send a letter to the applicant reaffirming that decision.

(e) If, after reviewing a request for reconsideration, the Department decides, based on the new facts and arguments submitted, to reconsider the application in light of the new information presented. The Department will then take whatever steps remained at the time it issued its final denial letter to process the exemption application.

(f) If, at any point during its subsequent processing of the application, the Department decides again that the exemption is unwarranted, it will issue a letter affirming its final denial.

§ 2570.46 Hearings in opposition to exemptions from restrictions on fiduciary self-dealing.

(a) Any interested person who may be adversely affected by an exemption which the Department proposes to grant from the restrictions of section 406(b) of ERISA, section 4975(c)(1)(E) or (F) of the Code, or section 8477(c)(2) of FERSA may request a hearing before the Department within the period of time specified in the FEDERAL REGISTER notice of the proposed exemption. Any such request must state:

(1) The name, address, telephone number, and email address of the person making the request;

(2) The nature of the person’s interest in the exemption and the manner in which the person would be adversely affected by the exemption; and

(3) A statement of the issues to be addressed and a general description of the evidence to be presented at the hearing.

(b) The Department will grant a request for a hearing made in accordance with paragraph (a) of this section where a hearing is necessary to fully explore material factual issues identified by the person requesting the hearing. A notice of such hearing shall be published by the Department in the FEDERAL REGISTER. The Department may decline to hold a hearing where:

(1) The request for the hearing does not meet the requirements of paragraph (a) of this section;

(2) The only issues identified for exploration at the hearing are matters of law; or

(3) The factual issues identified can be fully explored through the submission of evidence in written (including electronic) form.

(c) An applicant for an exemption must notify interested persons in the event that the Department schedules a hearing on the exemption. Such notification must be given in the form, time, and manner prescribed by the Department. Ordinarily, however, adequate notification can be given by providing to interested persons a copy of the notice of hearing published by the Department in the FEDERAL REGISTER.
within 10 days of its publication, using any of the methods approved in §2570.43(b).

(d) After furnishing the notice required by paragraph (c) of this section, an applicant must submit a statement confirming that notice was given in the form, manner, and time prescribed. This statement must be accompanied by a declaration under penalty of perjury attesting to the truth of the information provided in the statement, which is signed by a person qualified under §2570.34(b)(5) to sign such a declaration.

§ 2570.47 Other hearings.

(a) In its discretion, the Department may schedule a hearing on its own motion where it determines that issues relevant to the exemption can be most fully or expeditiously explored at a hearing. A notice of such hearing shall be published by the Department in the Federal Register.

(b) An applicant for an exemption must notify interested persons of any hearing on an exemption scheduled by the Department in the manner described in §2570.46(c). In addition, the applicant must submit a statement subscribed as true under penalty of perjury like that required in §2570.46(d).

§ 2570.48 Decision to grant exemptions.

(a) The Department may not grant an exemption under section 408(a) of ERISA, section 4975(c)(2) of the Code, or 5 U.S.C. 8477(c)(3) unless, following evaluation of the facts and representations comprising the administrative record of the proposed exemption (including any comments received in response to a notice of proposed exemption and the record of any hearing held in connection with the proposed exemption), it finds that the exemption is:

(1) Administratively feasible;

(2) In the interests of the plan (or the Thrift Savings Fund in the case of FERSA) and of its participants and beneficiaries; and

(3) Protective of the rights of participants and beneficiaries of such plan (or the Thrift Savings Fund in the case of FERSA).

(b) In each instance where the Department determines to grant an exemption, it shall publish a notice in the Federal Register which summarizes the transaction or transactions for which exemptive relief has been granted and specifies the conditions under which such exemptive relief is available.

§ 2570.49 Limits on the effect of exemptions.

(a) An exemption does not take effect with respect to the exemption transaction unless the material facts and representations contained in the application and in any materials and documents submitted in support of the application were true and complete.

(b) An exemption is effective only for the period of time specified and only under the conditions set forth in the exemption.

(c) Only the specific parties to whom an exemption grants relief may rely on the exemption. If the notice granting an exemption does not limit exemptive relief to specific parties, all parties to the exemption transaction may rely on the exemption.

(d) For transactions that are continuing in nature, an exemption ceases to be effective if, during the continuation of the transaction, there are material changes to the original facts and representations underlying such exemption or if one or more of the exemption’s conditions cease to be met.

(e) The determination as to whether, under the totality of the facts and circumstances, a particular statement contained in (or omitted from) an exemption application constitutes a material fact or representation is made by the Department.

§ 2570.50 Revocation or modification of exemptions.

(a) If, after an exemption takes effect, changes in circumstances, including changes in law or policy, occur which call into question the continuing validity of the Department’s original findings concerning the exemption, the Department may take steps to revoke or modify the exemption.

(b) Before revoking or modifying an exemption, the Department will publish a notice of its proposed action in
§ 2570.51

the FEDERAL REGISTER and provide interested persons with an opportunity to comment on the proposed revocation or modification. Prior to the publication of such notice, the applicant will be notified of the Department’s proposed action and the reasons therefore. Subsequent to the publication of the notice, the applicant will have the opportunity to comment on the proposed revocation or modification.

(c) Ordinarily the revocation or modification of an exemption will have prospective effect only.

§ 2570.51 Public inspection and copies.

(a) The administrative record of each exemption will be open to public inspection and copying at the EBSA Public Disclosure Room, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210.

(b) Upon request, the staff of the Public Disclosure Room will furnish photocopies of an administrative record, or any specified portion of that record, for a specified charge per page.

§ 2570.52 Effective date.

This subpart B is effective with respect to all exemptions filed with or initiated by the Department under section 408(a) of ERISA, section 4975(c)(2) of the Code, and/or 5 U.S.C. 8477(c)(3) at any time on or after December 27, 2011. Applications for exemptions under section 408(a) of ERISA, section 4975(c)(2) of the Code, and/or 5 U.S.C. 8477(c)(3) filed on or after September 10, 1990, but before December 27, 2011 are governed by part 2570 of chapter XXV of title 29 of the Code of Federal Regulations (title 29 CFR part 2570 as revised July 1, 1991).

Subpart C—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(2)

Source: 54 FR 26897, June 26, 1989, unless otherwise noted.

§ 2570.60 Scope of rules.

The rules of practice set forth in this subpart are applicable to “502(c)(2) civil penalty proceedings” (as defined in §2570.61(n) of this subpart) under section 502(c)(2) of the Employee Retirement Income Security Act of 1974. The rules of procedure for administrative hearings published by the Department’s Office of Law Judges at part 18 of this title will apply to matters arising under ERISA section 502(c)(2) except as modified by this section. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.61 Definitions.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of the definitions in §18.2 of this title:

(a) Adjudicatory proceeding means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;

(b) Administrative law judge means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) Answer means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to §2560.502c–2(g) of this chapter.

(d) Commencement of proceeding is the filing of an answer by the respondent;

(e) Consent agreement means any written document containing a specified remedy or other relief acceptable to the Department and consenting parties;

(f) ERISA means the Employee Retirement Income Security Act of 1974, as amended;

(g) Final Order means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(2) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of reasonable cause described in §2560.502c–2(e) within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;
Employee Benefits Security Admin., Labor § 2570.63

(h) Hearing means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) Order means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(2);

(j) Party includes a person or agency named or admitted as a party to a proceeding;

(k) Person includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(l) Petition means a written request, made by a person or party, for some affirmative action;

(m) Pleading means the notice as defined in §2560.502c–2(g), the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(n) 502(c)(2) civil penalty proceeding means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(2) of ERISA;

(o) Respondent means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(2);

(p) Secretary means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Employee Benefits Security), administrator, commissioner, appellate body, board, or other official; and

(q) Solicitor means the Solicitor of Labor or his or her delegate.

§ 2570.62 Service: Copies of documents and pleadings.

For 502(c)(2) penalty proceedings, this section shall apply in lieu of §18.3 of this title.

(a) General. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001-8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties or record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(2) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) Form of pleadings. (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ × 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.63 Parties, how designated.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of §18.10 of this title.
§ 2570.64
(a) The term “party” wherever used in these rules shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as “respondent.” The Department shall be designated as the “complainant.”
(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.
(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:
(1) Petitioner’s interest in the proceeding;
(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;
(3) Who will appear for petitioner;
(4) The issues on which petitioner wishes to participate; and
(5) Whether petitioner intends to present witnesses.
(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.65 Consent order or settlement.
For 502(c)(2) civil penalty proceedings, the following shall apply in lieu of §18.9 of this title.
(a) General. At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of
the parties and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) *Content.* Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

1. That the order shall have the same force and effect as an order made after full hearing;
2. That the entire record on which any order may be based shall consist solely of the notice and the agreement;
3. A waiver of any further procedural steps before the administrative law judge;
4. A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and
5. That the order and decision of the administrative law judge shall be final agency action.

(c) *Submission.* On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

1. Submit the proposed agreement containing consent findings and an order to the administrative law judge; or
2. Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or
3. Inform the administrative law judge that agreement cannot be reached.

(d) *Disposition.* In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefore, the administrative law judge shall issue a decision incorporating such findings and agreement within thirty (30) days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) *Settlement without consent of all parties.* In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

1. If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;
2. Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;
3. If any party submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;
4. If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.66 Scope of discovery.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of §18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish “good cause” for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery
to that for which “good cause” has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party’s representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representatives of a party concerning the proceeding.

§ 2570.67 Summary decision.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of §18.41 of this title.

(a) No genuine issue of material of fact.

(1) Where no issue of a material of fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§2570.69 through 2570.71 of this subpart, shall become a final order.

(2) A decision made under this paragraph shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) Hearings on issues of fact. Where a genuine question of material of fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.68 Decision of the administrative law judge.

For 502(c)(2) civil penalty proceedings, this section shall apply in lieu of §18.57 of this title.

(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony of such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge’s discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and briefs shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) Decision of the administrative law judge. Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefor on each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for 502(c)(2) civil penalty proceedings as set forth in this subpart, the penalty (if any) which may be included in the decision of the administrative law judge shall be limited to the penalty expressly provided for in section 502(c)(2) of ERISA. It shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§2570.69 through 2570.71.

§ 2570.69 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge.
Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.70 Scope of review.

The review of the Secretary shall not be de novo proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.71 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart D—Procedure for the Assessment of Civil Penalties Under ERISA Section 502(l)

SOURCE: 55 FR 25286, June 20, 1990, unless otherwise noted.
§ 2570.83 Assessment of civil penalty.

(a) Except as described in §§2570.85 and 2570.86 of this part, subsequent to the payment of the applicable recovery amount pursuant to either a settlement agreement or a court order, the Secretary shall serve on the person liable for making such payment a notice of assessment of civil penalty equal to 20 percent of the applicable recovery amount.

(b) Service of such notice shall be made either:

(1) By delivering a copy to the person being assessed; if the person is an individual, to the individual; if the person is a partnership, to any partner; if the person is a corporation, association, exchange, or other entity or organization, to any officer of such entity; if the person is an employee benefit plan, to a trustee of such plan; or to any attorney representing any such person;

(2) By leaving a copy at the principal office, place of business, or residence of such individual, partner, officer, trustee, or attorney; or

(3) By mailing a copy to the last known address of such individual, partner, officer, trustee, or attorney.

If service is accomplished by certified mail, service is complete upon mailing. If done by regular mail, service is complete upon receipt by the addressee.

§ 2570.84 Payment of civil penalty.

(a) The civil penalty must be paid within 60 days of service of the notice of assessment.

(b) At any time prior to the expiration of the payment period for the assessed penalty, any person who has committed, or knowingly participated in, a breach or violation, or has been alleged by the Secretary to have so committed or participated, may submit a written request for a conference with the Secretary to discuss the calculation of the assessed penalty. A person will be entitled under this section to one such conference per assessment. If such written request is submitted during the 60 day payment period described in subparagraph (a), such a request will not toll the running of that payment period.

(c) The notice of assessment will become a final order (within the meaning of 5 U.S.C. 704) on the first day following the 60 day payment period, subject to any tolling caused by a petition to waive or reduce described in §2570.85.

§ 2570.85 Waiver or reduction of civil penalty.

(a) At any time prior to the expiration of the payment period for the assessed penalty, any person who has committed, or knowingly participated in, a breach or violation, or has been alleged by the Secretary to have so committed or participated, may petition the Secretary to waive or reduce the penalty under this section on the basis that:

(1) The person acted reasonably and in good faith in engaging in the breach or violation; or

(2) The person will not be able to restore all losses to the plan or participant or beneficiary of such plan without severe financial hardship unless such waiver or reduction is granted.

(b) All petitions for waiver or reduction shall be in writing and contain the following information:
§ 2570.90 Scope of rules.

The rules of practice set forth in this subpart are applicable to “502(c)(5) civil penalty proceedings” (as defined in 2570.91(n)) under section 502(c)(5) of the Employee Retirement Income Security Act of 1974. The rules of procedure for administrative hearings published by the Department’s Office of Administrative Law Judges in subpart...
§ 2570.91 Definitions.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of the definitions in §18.2 of this title.

(a) *Adjudicatory proceeding* means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;

(b) *Administrative law judge* means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) *Answer* means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to 29 CFR 2560.502c–5(g);

(d) *Commencement of proceeding* is the filing of an answer by the respondent;

(e) *Consent agreement* means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) *ERISA* means the Employee Retirement Income Security Act of 1974, as amended;

(g) *Final order* means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(5) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of reasonable cause described in 29 CFR 2560.502c–5(e) within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(h) *Hearing* means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(i) *Order* means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(5);

(j) *Party* includes a person or agency named or admitted as a party to a proceeding;

(k) *Person* includes an individual, partnership, corporation, employee benefit plan, association, exchange, or other entity or organization;

(l) *Petition* means a written request, made by a person or party, for some affirmative action;

(m) *Pleading* means the notice as defined in 29 CFR 2560.502c–5(g), the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(n) *502(c)(5) civil penalty proceeding* means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(5) of ERISA;

(o) *Respondent* means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(5);

(p) *Secretary* means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Employee Benefits Security), administrator, commissioner, appellate body, board, or other official of the Department of Labor; and

(q) *Solicitor* means the Solicitor of Labor or his or her delegate.

§ 2570.92 Service: Copies of documents and pleadings.

For 502(c)(5) penalty proceedings, this section shall apply in lieu of 29 CFR 18.3.

(a) *In general.* Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have
been transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 502(c)(5) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) Form of pleadings—(1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ × 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.93 Parties, how designated.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of 29 CFR 18.10.

(a) The term party wherever used in this subpart shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as “respondent.” The Department shall be designated as the “complainant.”

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner’s interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days after the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner as well as the parties,
written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.94 Consequences of default.
For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of 29 CFR 18.5(a) and (b). Failure of the respondent to file an answer to the notice of determination described in 29 CFR 2560.502c–5(g) within the 30 day period provided by 29 CFR 2560.502c–5(h) shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(5) of the Act. Such notice shall then become a final order of the Secretary, within the meaning of § 2570.91(g), forty-five (45) days from the date of the service of the notice.

§ 2570.95 Consent order or settlement.
For 502(c)(5) civil penalty proceedings, the following shall apply in lieu of 29 CFR 18.9.

(a) In general. At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such deferment and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) Content. Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;
(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;
(3) A waiver of any further procedural steps before the administrative law judge;
(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and
(5) That the order and decision of the administrative law judge shall be final agency action.

(c) Submission. On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge;
(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or
(3) Inform the administrative law judge that agreement cannot be reached.

(d) Disposition. In the event that a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within thirty (30) days of receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become a final agency action within the meaning of 5 U.S.C. 704.

(e) Settlement without consent of all parties. In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must
receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;  
(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;  
(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether to sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;  
(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.96 Scope of discovery.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of 29 CFR 18.14.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish “good cause” for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which “good cause” has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party’s representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the proceeding.

§ 2570.97 Summary decision.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of 29 CFR 18.41.

(a) No genuine issue of material fact. (1) Where no issue of material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§2570.99 through 2570.101, shall become a final order.

(2) A decision made under this paragraph shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefore, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) Hearings on issues of fact. Where a genuine question of material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.98 Decision of the administrative law judge.

For 502(c)(5) civil penalty proceedings, this section shall apply in lieu of 29 CFR 18.57.

(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge’s discretion, proposed findings of fact, conclusions of law, and an order
§ 2570.99 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.100 Scope of review.

The review of the Secretary shall not be a de novo proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.101 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart F—Procedures for the Assessment of Civil Penalties Under ERISA Section 502(c)(6)

SOURCE: 67 FR 786, Jan. 7, 2002, unless otherwise noted.
proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.111 Definitions.
For section 502(c)(6) civil penalty proceedings, this section shall apply in lieu of the definitions in §18.2 of this title:
(a) Adjudicatory proceeding means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;
(b) Administrative law judge means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;
(c) Answer means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to §2560.502c–6(g) of this chapter;
(d) Commencement of proceeding is the filing of an answer by the respondent;
(e) Consent agreement means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;
(f) ERISA means the Employee Retirement Income Security Act of 1974, as amended;
(g) Final order means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(6) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of matters reasonably beyond the control of the plan administrator described in §2560.502c–6(e) of this chapter within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;
(h) Hearing means that part of a proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;
(i) Order means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(6);
(j) Party includes a person or agency named or admitted as a party to a proceeding;
(k) Person includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;
(l) Petition means a written request, made by a person or party, for some affirmative action;
(m) Pleading means the notice as defined in §2560.502c–6(g) of this chapter, the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;
(n) 502(c)(6) civil penalty proceeding means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(6) of ERISA;
(o) Respondent means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(6);
(p) Secretary means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Employee Benefits Security), administrator, commissioner, appellate body, board, or other official; and
(q) Solicitor means the Solicitor of Labor or his or her delegate.

§ 2570.112 Service: Copies of documents and pleadings.
For 502(c)(6) penalty proceedings, this section shall apply in lieu of §18.3 of this title.
(a) General. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.
(b) By parties. All motions, petitions, pleadings, briefs, or other documents
shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(6) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) Form of pleadings. (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8 1/2 x 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopied, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.113 Parties, how designated.

For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of §18.10 of this title.

(a) The term “party” wherever used in this subpart shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as “respondent.” The Department shall be designated as the “complainant”.

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person or organization who has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner’s interest in the proceeding;
(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;
(3) Who will appear for petitioner;
(4) The issues on which petitioner wishes to participate; and
(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioner has the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner, as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of
the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.114 Consequences of default.
For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of §18.5(a) and (b) of this title. Failure of the respondent to file an answer to the notice of determination described in §2560.502c–6(g) of this chapter within the 30 day period provided by §2560.502c–6(h) of this chapter shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(6) of the Act. Such notice shall then become the final order of the Secretary, within the meaning of §2570.111(g) of this subpart, forty-five (45) days from the date of service of the notice.

(68 FR 3738, Jan. 24, 2003)

§ 2570.115 Consent order or settlement.
For 502(c)(6) civil penalty proceedings, the following shall apply in lieu of §18.9 of this title.

(a) General. At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such a deferral and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties, and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) Content. Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;
(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;
(3) A waiver of any further procedural steps before the administrative law judge;
(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and
(5) That the order and decision of the administrative law judge shall be final agency action.

(c) Submission. On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or
(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or
(3) Inform the administrative law judge that agreement cannot be reached.

(d) Disposition. In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within 30 days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(5) Settlement without consent of all parties. In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge,


then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within 30 days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.116 Scope of discovery.
For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of §18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish "good cause" for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which "good cause" has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party’s representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representatives of a party concerning the proceeding.

§ 2570.117 Summary decision.
For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of §18.41 of this title.

(a) No genuine issue of material fact. (1) Where no issue of a material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§2570.119 through 2570.121 of this subpart, shall become a final order.

(2) A decision made under this paragraph (a) shall include a statement of:
(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and
(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) Hearings on issues of fact. Where a genuine question of a material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.118 Decision of the administrative law judge.
For 502(c)(6) civil penalty proceedings, this section shall apply in lieu of §18.57 of this title.

(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge’s discretion, proposed findings of
Employee Benefits Security Admin., Labor § 2570.130

§ 2570.130 Scope of rules.

The rules of practice set forth in this subpart are applicable to “502(c)(7) civil penalty proceedings” (as defined in §2570.131(n) of this subpart) under section 502(c)(7) of the Employee Retirement Income Security Act of 1974, as amended (the Act). The rules of procedure for administrative hearings published by the Department’s Office of Administrative Law Judges at Part 18...
of this title will apply to matters arising under ERISA section 502(c)(7) except as modified by this subpart. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.131 Definitions.

For 502(c)(7) civil penalty proceedings, this section shall apply in lieu of the definitions in §18.2 of this title:

(a) Adjudicatory proceeding means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;
(b) Administrative law judge means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;
(c) Answer means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to §2560.502c–7(g) of this chapter;
(d) Commencement of proceeding is the filing of an answer by the respondent;
(e) Consent agreement means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;
(f) ERISA means the Employee Retirement Income Security Act of 1974, as amended;
(g) Final order means the final decision or action of the Department of Labor concerning the assessment of a civil penalty under ERISA section 502(c)(7) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of reasonable cause described in §2560.502c–7(e) of this chapter within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;
(h) Hearing means that part of a proceeding which involves the submission of evidence, by either oral presentation or written submission, to the administrative law judge;
(i) Order means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(7);
(j) Party includes a person or agency named or admitted as a party to a proceeding;
(k) Person includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;
(l) Petition means a written request, made by a person or party, for some affirmative action;
(m) Pleading means the notice as defined in §2560.502c–7(g) of this chapter, the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;
(n) 502(c)(7) civil penalty proceeding means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(7) of ERISA;
(o) Respondent means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(7);
(p) Secretary means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Employee Benefits Security), administrator, commissioner, appellate body, board, or other official; and
(q) Solicitor means the Solicitor of Labor or his or her delegate.

§ 2570.132 Service: Copies of documents and pleadings.

For 502(c)(7) penalty proceedings, this section shall apply in lieu of §18.3 of this title.

(a) General. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.
(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(7) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) Form of pleadings. (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ x 11 inch paper.

(2) Illegible documents, whether handwritten, typewritten, photocopied, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.133 Parties, how designated.

For 502(c)(7) civil penalty proceedings, this section shall apply in lieu of §18.10 of this title.

(a) The term “party” wherever used in this subpart shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as “respondent.” The Department shall be designated as the “complainant.”

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person who or organization that has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner’s interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioner has the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner, as well as the parties, written notice of the decision on his or her petition. For each petition granted,
the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.134 Consequences of default.
For 502(c)(7) civil penalty proceedings, this section shall apply in lieu of §18.5(a) and (b) of this title. Failure of the respondent to file an answer to the notice of determination described in §2560.502c–7(g) of this chapter within the 30 day period provided by §2560.502c–7(h) of this chapter shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(7) of the Act. Such notice shall then become the final order of the Secretary, within the meaning of §2570.131(g) of this subpart, forty-five (45) days from the date of service of the notice.

§ 2570.135 Consent order or settlement.
For 502(c)(7) civil penalty proceedings, the following shall apply in lieu of §18.9 of this title.

(a) General. At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such a deferral and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties, and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) Consent. Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

1. That the order shall have the same force and effect as an order made after full hearing;
2. That the entire record on which any order may be based shall consist solely of the notice and the agreement;
3. A waiver of any further procedural steps before the administrative law judge;
4. A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and
5. That the order and decision of the administrative law judge shall be final agency action.

(c) Submission. On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

1. Submit the proposed agreement containing consent findings and an order to the administrative law judge; or
2. Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or
3. Inform the administrative law judge that agreement cannot be reached.

(d) Disposition. In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within 30 days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) Settlement without consent of all parties. In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

1. If all of the parties have not consented to the proposed settlement submitted to the administrative law judge,
then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;

(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within 30 days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.136 Scope of discovery.

For 502(c)(7) civil penalty proceedings, this section shall apply in lieu of § 18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery shall be granted by the administrative law judge only upon a showing of good cause. In order to establish “good cause” for the purposes of this section, a party must show that the discovery requested relates to a genuine issue as to a material fact that is relevant to the proceeding. The order of the administrative law judge shall expressly limit the scope and terms of discovery to that for which “good cause” has been shown, as provided in this paragraph.

(b) A party may obtain discovery of documents and tangible things otherwise discoverable under paragraph (a) of this section and prepared in anticipation of or for the hearing by or for another party’s representative (including his or her attorney, consultant, surety, indemnitor, insurer, or agent) only upon showing that the party seeking discovery has substantial need of the materials or information in the preparation of his or her case and that he or she is unable without undue hardship to obtain the substantial equivalent of the materials or information by other means. In ordering discovery of such materials when the required showing has been made, the administrative law judge shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representatives of a party concerning the proceeding.

§ 2570.137 Summary decision.

For 502(c)(7) civil penalty proceedings, this section shall apply in lieu of § 18.41 of this title.

(a) No genuine issue of material fact. (1) Where no issue of a material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§ 2570.139 through 2570.141 of this subpart, shall become a final order.

(2) A decision made under paragraph (a) of this section shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(3) A copy of any decision under this paragraph shall be served on each party.

(b) Hearings on issues of fact. Where a genuine question of a material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.138 Decision of the administrative law judge.

For 502(c)(7) civil penalty proceedings, this section shall apply in lieu of § 18.57 of this title.

(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the
§ 2570.139 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.140 Scope of review.

The review of the Secretary shall not be a de novo proceeding but rather a review of the record established before the administrative law judge. The review shall be no opportunity for oral argument.

§ 2570.141 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

Subpart H—Procedures for Issuance of Findings Under ERISA Sec. 3(40)

§ 2570.150 Scope of rules.

The rules of practice set forth in this subpart H apply to “section 3(40) Finding Proceedings” (as defined in §2570.152(g)), under section 3(40) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act). Refer to 29 CFR 2510.3–40 for the definition of relevant terms of section 3(40) of ERISA, 29 U.S.C. 1002(40). To the extent that the regulations in this subpart differ from the regulations in subpart A of 29 CFR part 18, the regulations in this
subpart apply to matters arising under section 3(40) of ERISA rather than the rules of procedure for administrative hearings published by the Department’s Office of Administrative Law Judges in subpart A of 29 CFR part 18. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.151 In general.
If there is an attempt to assert state jurisdiction or the application of state law, either by the issuance of a state administrative or court subpoena to, or the initiation of administrative or judicial proceedings against, a plan or other arrangement that alleges it is covered by title I of ERISA, 29 U.S.C. 1003, the plan or other arrangement may petition the Secretary to make a finding under section 3(40)(A)(i) of ERISA that it is a plan established or maintained under or pursuant to one or more collective bargaining agreements for purposes of section 3(40) of ERISA.

§ 2570.152 Definitions.
For section 3(40) Finding Proceedings, this section shall apply instead of the definitions in 29 CFR 18.2.
(b) Order means the whole or part of a final procedural or substantive disposition by the administrative law judge of a matter under section 3(40) of ERISA. No order will be appealable to the Secretary except as provided in this subpart.
(c) Petition means a written request under the procedures in this subpart for a finding by the Secretary under section 3(40) of ERISA that a plan is established or maintained under or pursuant to one or more collective bargaining agreements.
(d) Petitioner means the plan or arrangement filing a petition.
(e) Respondent means:
(1) A state government instrumentality charged with enforcing the law that is alleged to apply or which has been identified as asserting jurisdiction over a plan or other arrangement, including any agency, commission, board, or committee charged with investigating and enforcing state insurance laws, including parties joined under § 2570.153;
(2) The person or entity asserting that state law or state jurisdiction applies to the petitioner;
(3) The Secretary of Labor; and
(4) A state not named in the petition that has intervened under § 2570.153(b).
(f) Secretary means the Secretary of Labor, and includes, pursuant to any delegation or sub-delegation of authority, the Assistant Secretary for Employee Benefits Security or other employee of the Employee Benefits Security Administration.
(g) Section 3(40) Finding Proceeding means a proceeding before the Office of Administrative Law Judges (OALJ) relating to whether the Secretary finds an entity to be a plan to be established or maintained under or pursuant to one or more collective bargaining agreements within the meaning of section 3(40) of ERISA.

§ 2570.153 Parties.
For section 3(40) Finding Proceedings, this section shall apply instead of 29 CFR 18.10.
(a) The term “party” with respect to a Section 3(40) Finding Proceeding means the petitioner and the respondents.
(b) States not named in the petition may participate as parties in a Section 3(40) Finding Proceeding by notifying the OALJ and the other parties in writing prior to the date for filing a response to the petition. After the date for service of responses to the petition, a state not named in the petition may intervene as a party only with the consent of all parties or as otherwise ordered by the ALJ.
(c) The Secretary of Labor shall be named as a “respondent” to all actions.
(d) The failure of any party to comply with any order of the ALJ may, at the discretion of the ALJ, result in the denial of the opportunity to present evidence in the proceeding.
§ 2570.154 Filing and contents of petition.

(a) A person seeking a finding under section 3(40) of ERISA must file a written petition by delivering or mailing it to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or by making a filing by any electronic means permitted under procedures established by the OALJ.

(b) The petition shall—

(1) Provide the name and address of the entity for which the petition is filed;

(2) Provide the names and addresses of the plan administrator and plan sponsor(s) of the plan or other arrangement for which the finding is sought;

(3) Identify the state or states whose law or jurisdiction the petitioner claims has been asserted over the petitioner, and provide the addresses and names of responsible officials;

(4) Include affidavits or other written evidence showing that:

(i) State jurisdiction has been asserted over or legal process commenced against the petitioner pursuant to state law;

(ii) The petitioner is an employee welfare benefit plan as defined in section 3(1) of ERISA (29 U.S.C. 1002(1)) and 29 CFR 2510.3–1 and is covered by title I of ERISA (see 29 U.S.C. 1003);

(iii) The petitioner is established or maintained for the purpose of offering or providing benefits described in section 3(1) of ERISA (29 U.S.C. 1002(1)) to employees of two or more employers (including one or more self-employed individuals) or their beneficiaries;

(iv) The petitioner satisfies the criteria in 29 CFR 2510.3–40(b); and

(v) Service has been made as provided in §2570.155.

(5) The affidavits shall set forth such facts as would be admissible in evidence in a proceeding under 29 CFR part 18 and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The affidavit or other written evidence must set forth specific facts showing the factors required under paragraph (b)(4) of this section.

§ 2570.155 Service.

For section 3(40) proceedings, this section shall apply instead of 29 CFR 18.3.

(a) In general. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges (OALJ), 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing by first class, prepaid U.S. mail, a copy to the last known address. The Secretary shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 3(40) Proceeding, PO Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made to all parties of record by regular mail to their last known address.

(d) Form of pleadings (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the OALJ and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ × 11 inch paper.
(2) Illegible documents, whether handwritten, typewritten, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.

§ 2570.156 Expedited proceedings.

For section 3(40) Finding Proceedings, this section shall apply instead of 29 CFR 18.42.

(a) At any time after commencement of a proceeding, any party may move to advance the scheduling of a proceeding, including the time for conducting discovery.

(b) Except when such proceedings are directed by the Chief Administrative Law Judge or the administrative law judge assigned, any party filing a motion under this section shall:

(1) Make the motion in writing;
(2) Describe the circumstances justifying advancement;
(3) Describe the irreparable harm that would result if the motion is not granted; and
(4) Incorporate in the motion affidavits to support any representations of fact.

(c) Service of a motion under this section shall be accomplished by personal delivery, or by facsimile, followed by first class, prepaid, U.S. mail. Service is complete upon personal delivery or mailing.

(d) Except when such proceedings are required, or unless otherwise directed by the Chief Administrative Law Judge or the administrative law judge assigned, all parties to the proceeding in which the motion is filed shall have ten (10) days from the date of service of the motion to file an opposition in response to the motion.

(e) Following the timely receipt by the administrative law judge of statements in response to the motion, the administrative law judge may advance pleading schedules, discovery schedules, prehearing conferences, and the hearing, as deemed appropriate; provided, however, that a hearing on the merits shall not be scheduled with less than five (5) working days notice to the parties, unless all parties consent to an earlier hearing.

(f) When an expedited hearing is held, the decision of the administrative law judge shall be issued within twenty (20) days after receipt of the transcript of any oral hearing or within twenty (20) days after the filing of all documentary evidence if no oral hearing is conducted.

§ 2570.157 Allocation of burden of proof.

For purposes of a final decision under § 2570.158 (Decision of the Administrative Law Judge) or § 2570.159 (Review by the Secretary), the petitioner shall have the burden of proof as to whether it meets 29 CFR 2510.3–40.

§ 2570.158 Decision of the Administrative Law Judge.

For section 3(40) finding proceedings, this section shall apply instead of 29 CFR 18.57.

(a) Proposed findings of fact, conclusions of law, and order. Within twenty (20) days of filing the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion under 29 CFR 18.55, proposed findings of fact, conclusions of law, and order together with the supporting brief expressing the reasons for such proposals. Such proposals and brief shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) Decision based on oral argument in lieu of briefs. In any case in which the administrative law judge believes that written briefs or proposed findings of fact and conclusions of law may not be necessary, the administrative law judge shall notify the parties at the opening of the hearing or as soon thereafter as is practicable that he or she may wish to hear oral argument in lieu of briefs. The administrative law judge shall issue his or her decision at the close of oral argument, or within 30 days thereafter.

(c) Decision of the administrative law judge. Within 30 days, or as soon as possible thereafter, after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent
findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law, with reasons therefore, upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. It shall be supported by reliable and probative evidence. Such decision shall be in accordance with the regulations found at 29 CFR 2510.3–40 and shall be limited to whether the petitioner, based on the facts presented at the time of the proceeding, is a plan established or maintained under or pursuant to collective bargaining for the purposes of section 3(40) of ERISA.

§ 2570.159 Review by the Secretary.

(a) A request for review by the Secretary of an appealable decision of the administrative law judge may be made by any party. Such a request must be filed within 20 days of the issuance of the final decision or the final decision of the administrative law judge will become the final agency order for purposes of 5 U.S.C. 701 et seq.

(b) A request for review by the Secretary shall state with specificity the issue(s) in the administrative law judge’s final decision upon which review is sought. The request shall be served on all parties to the proceeding.

(c) The review by the Secretary shall not be a de novo proceeding but rather a review of the record established by the administrative law judge.

(d) The Secretary may, in his or her discretion, allow the submission of supplemental briefs by the parties to the proceeding.

(e) The Secretary shall issue a decision as promptly as possible, affirming, modifying, or setting aside, in whole or in part, the decision under review, and shall set forth a brief statement of reasons therefor. Such decision by the Secretary shall be the final agency action within the meaning of 5 U.S.C. 704.

Source: 75 FR 8801, Feb. 26, 2010, unless otherwise noted.

§ 2570.160 Scope of rules.

The rules of practice set forth in this subpart are applicable to “502(c)(8) civil penalty proceedings” (as defined in § 2570.161(n) of this subpart) under section 502(c)(8) of the Employee Retirement Income Security Act of 1974, as amended (the Act). The rules of procedure for administrative hearings published by the Department’s Office of Administrative Law Judges at Part 18 of this title will apply to matters arising under ERISA section 502(c)(8) except as modified by this subpart. These proceedings shall be conducted as expeditiously as possible, and the parties shall make every effort to avoid delay at each stage of the proceedings.

§ 2570.161 Definitions.

For 502(c)(8) civil penalty proceedings, this section shall apply in lieu of the definitions in § 18.2 of this title:

(a) Adjudicatory proceeding means a judicial-type proceeding before an administrative law judge leading to the formulation of a final order;

(b) Administrative law judge means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) Answer means a written statement that is supported by reference to specific circumstances or facts surrounding the notice of determination issued pursuant to § 2560.502c–8(g) of this chapter;

(d) Commencement of proceeding is the filing of an answer by the respondent;

(e) Consent agreement means any written document containing a specified proposed remedy or other relief acceptable to the Department and consenting parties;

(f) ERISA means the Employee Retirement Income Security Act of 1974, as amended;

(g) Final order means the final decision or action of the Department of
Labor concerning the assessment of a civil penalty under ERISA section 502(c)(8) against a particular party. Such final order may result from a decision of an administrative law judge or the Secretary, the failure of a party to file a statement of reasonable cause described in §2560.502c–8(e) of this chapter within the prescribed time limits, or the failure of a party to invoke the procedures for hearings or appeals under this title within the prescribed time limits. Such a final order shall constitute final agency action within the meaning of 5 U.S.C. 704;

(h) Hearing means that part of a proceeding which involves the submission of evidence, by either oral presentation or written submission, to the administrative law judge;

(i) Order means the whole or any part of a final procedural or substantive disposition of a matter under ERISA section 502(c)(8);

(j) Party includes a person or agency named or admitted as a party to a proceeding;

(k) Person includes an individual, partnership, corporation, employee benefit plan, association, exchange or other entity or organization;

(l) Petition means a written request, made by a person or party, for some affirmative action;

(m) Pleading means the notice as defined in §2560.502c–8(g) of this chapter, the answer to the notice, any supplement or amendment thereto, and any reply that may be permitted to any answer, supplement or amendment;

(n) 502(c)(8) civil penalty proceeding means an adjudicatory proceeding relating to the assessment of a civil penalty provided for in section 502(c)(8) of ERISA;

(o) Respondent means the party against whom the Department is seeking to assess a civil sanction under ERISA section 502(c)(8);

(p) Secretary means the Secretary of Labor and includes, pursuant to any delegation of authority by the Secretary, any assistant secretary (including the Assistant Secretary for Employee Benefits Security), administrator, commissioner, appellate body, board, or other official; and

(q) Solicitor means the Solicitor of Labor or his or her delegate.

§ 2570.162 Service: Copies of documents and pleadings.

For 502(c)(8) penalty proceedings, this section shall apply in lieu of §18.3 of this title.

(a) General. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street, NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Department shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA section 502(c)(8) Proceeding, P.O. Box 1914, Washington, DC 20013. The person serving the document shall certify to the manner and date of service.

(c) By the Office of Administrative Law Judges. Service of orders, decisions and all other documents shall be made by regular mail to the last known address.

(d) Form of pleadings. (1) Every pleading shall contain information indicating the name of the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be typewritten when possible on standard size 8½ x 11-inch paper.
§ 2570.163 Parties, how designated.

For 502(c)(8) civil penalty proceedings, this section shall apply in lieu of §18.10 of this title.

(a) The term “party” wherever used in this subpart shall include any natural person, corporation, employee benefit plan, association, firm, partnership, trustee, receiver, agency, public or private organization, or government agency. A party against whom a civil penalty is sought shall be designated as “respondent.” The Department shall be designated as the “complainant.”

(b) Other persons or organizations shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the proceedings and their interest is not adequately represented by existing parties, and that in the discretion of the administrative law judge the participation of such persons or organizations would be appropriate.

(c) A person or organization not named as a respondent wishing to participate as a party under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person or organization has knowledge of or should have known about the proceeding. The petition shall be filed with the administrative law judge and served on each person who or organization that has been made a party at the time of filing. Such petition shall concisely state:

(1) Petitioner’s interest in the proceeding;

(2) How his or her participation as a party will contribute materially to the disposition of the proceeding;

(3) Who will appear for petitioner;

(4) The issues on which petitioner wishes to participate; and

(5) Whether petitioner intends to present witnesses.

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioner has the requisite interest to be a party in the proceedings, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where petitions to participate as parties are made by individuals or groups with common interests, the administrative law judge may request all such petitioners to designate a single representative, or he or she may recognize one or more of such petitioners. The administrative law judge shall give each such petitioner, as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and shall then treat the petition as a request for participation as amicus curiae.

§ 2570.164 Consequences of default.

For 502(c)(8) civil penalty proceedings, this section shall apply in lieu of §18.5(a) and (b) of this title. Failure of the respondent to file an answer to the notice of determination described in §2560.502c–8(g) of this chapter within the 30 day period provided by §2560.502c–8(h) of this chapter shall be deemed to constitute a waiver of his or her right to appear and contest the allegations of the notice of determination, and such failure shall be deemed to be an admission of the facts as alleged in the notice for purposes of any proceeding involving the assessment of a civil penalty under section 502(c)(8) of the Act. Such notice shall then become the final order of the Secretary, within the meaning of §2570.161(g) of this subpart, forty-five (45) days from the date of service of the notice.

§ 2570.165 Consent order or settlement.

For 502(c)(8) civil penalty proceedings, the following shall apply in lieu of §18.9 of this title.

(a) General. At any time after the commencement of a proceeding, but at least five (5) days prior to the date set for hearing, the parties jointly may
move to defer the hearing for a reasonable time to permit negotiation of a settlement or an agreement containing findings and an order disposing of the whole or any part of the proceeding. The allowance of such a deferral and the duration thereof shall be in the discretion of the administrative law judge, after consideration of such factors as the nature of the proceeding, the requirements of the public interest, the representations of the parties, and the probability of reaching an agreement which will result in a just disposition of the issues involved.

(b) Content. Any agreement containing consent findings and an order disposing of a proceeding or any part thereof shall also provide:

(1) That the order shall have the same force and effect as an order made after full hearing;
(2) That the entire record on which any order may be based shall consist solely of the notice and the agreement;
(3) A waiver of any further procedural steps before the administrative law judge;
(4) A waiver of any right to challenge or contest the validity of the order and decision entered into in accordance with the agreement; and
(5) That the order and decision of the administrative law judge shall be final agency action.

(c) Submission. On or before the expiration of the time granted for negotiations, but, in any case, at least five (5) days prior to the date set for hearing, the parties or their authorized representative or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge; or
(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or
(3) Inform the administrative law judge that agreement cannot be reached.

(d) Disposition. In the event a settlement agreement containing consent findings and an order is submitted within the time allowed therefor, the administrative law judge shall issue a decision incorporating such findings and agreement within 30 days of his receipt of such document. The decision of the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become final agency action within the meaning of 5 U.S.C. 704.

(e) Settlement without consent of all parties. In cases in which some, but not all, of the parties to a proceeding submit a consent agreement to the administrative law judge, the following procedure shall apply:

(1) If all of the parties have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice, and a copy, of the proposed settlement at the time it is submitted to the administrative law judge;
(2) Any non-consenting party shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;
(3) If any party submits an objection to the proposed settlement, the administrative law judge shall decide within 30 days after receipt of such objections whether he shall sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issues may reasonably be based;
(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section.

§ 2570.166 Scope of discovery.

For 502(c)(8) civil penalty proceedings, this section shall apply in lieu of §18.14 of this title.

(a) A party may file a motion to conduct discovery with the administrative law judge. The motion for discovery
§ 2570.167 Summary decision.

For 502(c)(8) civil penalty proceedings, this section shall apply in lieu of §18.41 of this title.

(a) No genuine issue of material fact. (1) Where no issue of a material fact is found to have been raised, the administrative law judge may issue a decision which, in the absence of an appeal pursuant to §§2570.169 through 2570.171 of this subpart, shall become a final order.

(2) A decision made under paragraph (a) of this section shall include a statement of:

(i) Findings of fact and conclusions of law, and the reasons therefor, on all issues presented; and

(ii) Any terms and conditions of the rule or order.

(b) Hearings on issues of fact. Where a genuine question of a material fact is raised, the administrative law judge shall, and in any other case may, set the case for an evidentiary hearing.

§ 2570.168 Decision of the administrative law judge.

For 502(c)(8) civil penalty proceedings, this section shall apply in lieu of §18.57 of this title.

(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge's discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and briefs shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) Decision of the administrative law judge. Within a reasonable time after the time allowed for the filing of the proposed findings of fact, conclusions of law, and order, or within thirty (30) days after receipt of an agreement containing consent findings and order disposing of the disputed matter in whole, the administrative law judge shall make his or her decision. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefor upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record. In a contested case in which the Department and the Respondent have presented their positions to the administrative law judge pursuant to the procedures for 502(c)(8) civil penalty proceedings as set forth in this subpart, the penalty (if any) which may be included in the decision of the administrative law judge shall be limited to the penalty expressly provided for in section 502(c)(8) of ERISA. It
shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§2570.169 through 2570.171 of this subpart.

§ 2570.169 Review by the Secretary.

(a) The Secretary may review a decision of an administrative law judge. Such a review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of a notice of appeal, the Secretary shall request the Chief Administrative Law Judge to submit to him or her a copy of the entire record before the administrative law judge.

§ 2570.170 Scope of review.

The review of the Secretary shall not be a de novo proceeding but rather a review of the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2570.171 Procedures for review by the Secretary.

(a) Upon receipt of the notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in his or her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be final agency action within the meaning of 5 U.S.C. 704.

PART 2571—PROCEDURAL REGULATIONS FOR ADMINISTRATION AND ENFORCEMENT UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT

Subpart A—Procedures for Administrative Hearings on the Issuance of Cease and Desist Orders Under ERISA Section 521—Multiple Employer Welfare Arrangements

§ 2571.1 Scope of rules.

The rules of practice set forth in this part apply to ex parte cease and desist order proceedings under section 521 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The rules of procedure for administrative hearings published by the Department’s Office of Administrative Law Judges at Part 18 of this Title will apply to matters arising under ERISA section 521 except as modified by this section. These proceedings shall be
§ 2571.2 Definitions.

For section 521 proceedings, this section shall apply in lieu of the definitions in § 18.2 of this title:

(a) Adjudicatory proceeding means a judicial-type proceeding before an administrative law judge leading to an order;

(b) Administrative law judge means an administrative law judge appointed pursuant to the provisions of 5 U.S.C. 3105;

(c) Answer means a written statement that is supported by reference to specific circumstances or facts surrounding the temporary order issued pursuant to 29 CFR 2560.521–1(c);

(d) Commencement of proceeding is the filing of an answer by the respondent;

(e) Consent agreement means a proposed written agreement and order containing a specified proposed remedy or other relief acceptable to the Secretary and consenting parties;

(f) Final order means a cease and desist order that is a final order of the Secretary of Labor under ERISA section 521. Such final order may result from a decision of an administrative law judge or from the Secretary on review of a decision of an administrative law judge, or from the failure of a party to invoke the procedures for a hearing under 29 CFR 2560.521–1 within the prescribed time limit. A final order shall constitute a final agency action within the meaning of 5 U.S.C. 704;

(g) Hearing means that part of a section 521 proceeding which involves the submission of evidence, either by oral presentation or written submission, to the administrative law judge;

(h) Order means the whole or any part of a final procedural or substantive disposition of a section 521 proceeding;

(i) Party includes a person or agency named or admitted as a party to a section 521 proceeding;

(j) Person includes an individual, partnership, corporation, employee welfare benefit plan, association, or other entity or organization;

(k) Petition means a written request, made by a person or party, for some affirmative action;

(l) Respondent means the party against whom the Secretary is seeking to impose a cease and desist order under ERISA section 521;

(m) Secretary means the Secretary of Labor or his or her delegate;

(n) Section 521 proceeding means an adjudicatory proceeding relating to the issuance of a temporary order under 29 CFR 2560.521–1 and section 521 of ERISA;

(o) Solicitor means the Solicitor of Labor or his or her delegate; and

(p) Temporary order means the temporary cease and desist order issued by the Secretary under 29 CFR 2560.521–1(c) and section 521 of ERISA.

§ 2571.3 Service: copies of documents and pleadings.

For section 521 proceedings, this section shall apply in lieu of § 18.3 of this title:

(a) In general. Copies of all documents shall be served on all parties of record. All documents should clearly designate the docket number, if any, and short title of all matters. All documents to be filed shall be delivered or mailed to the Chief Docket Clerk, Office of Administrative Law Judges, 800 K Street NW., Suite 400, Washington, DC 20001–8002, or to the OALJ Regional Office to which the section 521 proceeding may have been transferred for hearing. Each document filed shall be clear and legible.

(b) By parties. All motions, petitions, pleadings, briefs, or other documents shall be filed with the Office of Administrative Law Judges with a copy, including any attachments, to all other parties of record. When a party is represented by an attorney, service shall be made upon the attorney. Service of any document upon any party may be made by personal delivery or by mailing a copy to the last known address. The Secretary shall be served by delivery to the Associate Solicitor, Plan Benefits Security Division, ERISA Section 521 Proceeding, P.O. Box 1914, Washington, DC 20013 and any attorney named for service of process as set
forth in the temporary order. The person serving the document shall certify to the manner of date and service.  

(c) By the Office of Administrative Law Judges. Service of orders, decisions, and all other documents shall be made in such manner as the Office of Administrative Law Judges determines to the last known address.  

(d) Form of pleadings.  

(1) Every pleading or other paper filed in a section 521 proceeding shall designate the Employee Benefits Security Administration (EBSA) as the agency under which the proceeding is instituted, the title of the proceeding, the docket number (if any) assigned by the Office of Administrative Law Judges and a designation of the type of pleading or paper (e.g., notice, motion to dismiss, etc.). The pleading or paper shall be signed and shall contain the address and telephone number of the party or person representing the party. Although there are no formal specifications for documents, they should be printed when possible on standard size 8½ × 11 inch paper.  

(2) Illegible documents, whether handwritten, printed, photocopies, or otherwise, will not be accepted. Papers may be reproduced by any duplicating process provided all copies are clear and legible.  

§ 2571.4 Parties.  

For section 521 proceedings, this section shall apply in lieu of §18.10 of this title:  

(a) The term “party” wherever used in these rules shall include any person that is a subject of the temporary order and is challenging the temporary order under these section 521 proceedings, and the Secretary. A party challenging a temporary order shall be designated as the “respondent.” The Secretary shall be designated as the “complainant.”  

(b) Other persons shall be permitted to participate as parties only if the administrative law judge finds that the final decision could directly and adversely affect them or the class they represent, that they may contribute materially to the disposition of the section 521 proceeding and their interest is not adequately represented by the existing parties, and that in the discretion of the administrative law judge the participation of such persons would be appropriate.  

(c) A person not named in a temporary order, but wishing to participate as a respondent under this section shall submit a petition to the administrative law judge within fifteen (15) days after the person has knowledge of, or should have known about, the section 521 proceeding. The petition shall be filed with the administrative law judge and served on each person who has been made a party at the time of filing. Such petition shall concisely state:  

(1) Petitioner’s interest in the section 521 proceeding (including how the section 521 proceedings will directly and adversely affect them or the class they represent and why their interest is not adequately represented by the existing parties);  

(2) How his or her participation as a party will contribute materially to the disposition of the section 521 proceeding;  

(3) Who will appear for the petitioner;  

(4) The issues on which petitioner wishes to participate; and  

(5) Whether petitioner intends to present witnesses.  

(d) Objections to the petition may be filed by a party within fifteen (15) days of the filing of the petition. If objections to the petition are filed, the administrative law judge shall then determine whether petitioners have the requisite interest to be a party in the section 521 proceeding, as defined in paragraph (b) of this section, and shall permit or deny participation accordingly. Where persons with common interest file petitions to participate as parties in a section 521 proceeding, the administrative law judge may request all such petitioners to designate a single representative, or the administrative law judge may designate one or more of the petitioners to represent the others. The administrative law judge shall give each such petitioner, as well as the parties, written notice of the decision on his or her petition. For each petition granted, the administrative law judge shall provide a brief statement of the basis of the decision. If the petition is denied, he or she shall briefly state the grounds for denial and
§ 2571.5

Consequences of default.

For section 521 proceedings, this section shall apply in lieu of §18.5(b) of this title. Failure of the respondent to file an answer to the temporary order within the 30-day period provided by 29 CFR 2560.521–1(e) shall constitute a waiver of the respondent’s right to appear and contest the temporary order. Such failure shall also be deemed to be an admission of the facts as alleged in the temporary order for purposes of any proceeding involving the order issued under section 521 of ERISA. The temporary order shall then become the final order of the Secretary, within the meaning of 29 CFR 2571.2(f), 30 days from the date of the service of the temporary order.

§ 2571.6 Consent order or settlement.

For section 521 proceedings, this section shall apply in lieu of §18.9 of this title:

(a) In general. At any time after the commencement of a section 521 proceeding, the parties jointly may move to defer the hearing for a reasonable time in order to negotiate a settlement or an agreement containing findings and a consent order disposing of the whole or any part of the section 521 proceeding. The administrative law judge shall have discretion to allow or deny such a postponement and to determine its duration. In exercising this discretion, the administrative law judge shall consider the nature of the section 521 proceeding, the requirements of the public interest, the representations of the parties and the probability of reaching an agreement that will result in a just disposition of the issues involved.

(b) Content. Any agreement containing consent findings and an order disposing of the section 521 proceeding or any part thereof shall also provide:

(1) That the consent order shall have the same force and effect as an order made after full hearing;

(2) That the entire record on which the consent order is based shall consist solely of the notice and the agreement;

(3) A waiver of any further procedural steps before the administrative law judge;

(4) A waiver of any right to challenge or contest the validity of the consent order and decision entered into in accordance with the agreement; and

(5) That the consent order and decision of the administrative law judge shall be final agency action within the meaning of 5 U.S.C. 704.

(c) Submission. On or before the expiration of the time granted for negotiations, the parties or their authorized representatives or their counsel may:

(1) Submit the proposed agreement containing consent findings and an order to the administrative law judge;

(2) Notify the administrative law judge that the parties have reached a full settlement and have agreed to dismissal of the action subject to compliance with the terms of the settlement; or

(3) Inform the administrative law judge that agreement cannot be reached.

(d) Disposition. If a settlement agreement containing consent findings and an order, agreed to by all the parties to a section 521 proceeding, is submitted within the time allowed therefor, the administrative law judge shall incorporate all of the findings, terms, and conditions of the settlement agreement and consent order of the parties. Such decision shall become a final agency action within the meaning of 5 U.S.C. 704.

(e) Settlement without consent of all respondents. In cases in which some, but not all, of the respondents to a section 521 proceeding submit an agreement and consent order to the administrative law judge, the following procedure shall apply:

(1) If all of the respondents have not consented to the proposed settlement submitted to the administrative law judge, then such non-consenting parties must receive notice and a copy of the proposed settlement at the time it is submitted to the administrative law judge;

(2) Any non-consenting respondent shall have fifteen (15) days to file any objections to the proposed settlement with the administrative law judge and all other parties;
(3) If any respondent submits an objection to the proposed settlement, the administrative law judge shall decide within thirty (30) days after receipt of such objections whether to sign or reject the proposed settlement. Where the record lacks substantial evidence upon which to base a decision or there is a genuine issue of material fact, then the administrative law judge may establish procedures for the purpose of receiving additional evidence upon which a decision on the contested issue may be reasonably based;

(4) If there are no objections to the proposed settlement, or if the administrative law judge decides to sign the proposed settlement after reviewing any such objections, the administrative law judge shall incorporate the consent agreement into a decision meeting the requirements of paragraph (d) of this section; and

(5) If the consent agreement is incorporated into a decision meeting the requirements of paragraph (d) of this section, the administrative law judge shall continue the section 521 proceeding with respect to any non-consenting respondents.

§ 2571.7 Scope of discovery.

For section 521 proceedings, this section shall apply in lieu of §18.14 of this title:

(a) A party may file a motion to conduct discovery with the administrative law judge. The administrative law judge may grant a motion for discovery only upon a showing of good cause. In order to establish “good cause” for the purposes of this section, the moving party must show that the requested discovery relates to a genuine issue as to a fact that is material to the section 521 proceeding. The order of the administrative law judge shall expressly limit the scope and terms of the discovery to that for which “good cause” has been shown, as provided in this paragraph.

(b) Any evidentiary privileges apply as they would apply in a civil proceeding in federal district court. For example, legal advice provided by an attorney to a client is generally protected from disclosure. Mental impressions, conclusions, opinions, or legal theories of a party’s attorney or other representative developed in anticipation of litigation are also generally protected from disclosure. The administrative law judge may not, however, protect from discovery or use, relevant communications between an attorney and a plan administrator or other plan fiduciary, or work product, that fall under the fiduciary exception to the attorney-client or work product privileges. The fiduciary exception to these privileges exists when an attorney advises the plan administrator or other plan fiduciary on matters concerning plan administration or other fiduciary activities. Consequently, the administrative law judge may not protect such communications from discovery or from use by the Secretary in the proceedings. The administrative law judge also may also not protect attorney work product prepared to assist the fiduciary in its fiduciary capacity from discovery or from use by the Secretary in the proceedings. The fiduciary exception does not apply, however, to the extent that communications were made or documents were prepared exclusively to aid the fiduciary personally or for non-fiduciary matters (e.g., settlor acts), provided that the plan did not pay for the legal services. The Secretary need not make a special showing, such as good cause, merely to obtain information or documents covered by the fiduciary exception. Other relevant exceptions to the attorney-client or work product privileges shall also apply.

§ 2571.8 Summary decision.

For section 521 proceedings, this section shall apply in lieu of §18.41 of this title:

(a) No genuine issue of material fact. Where the administrative law judge finds that no issue of a material fact has been raised, he or she may issue a decision which, in the absence of an appeal, pursuant to §§2571.10 through 2571.12, shall become a final agency action within the meaning of 5 U.S.C. 704.

(b) A decision made under this section, shall include a statement of:

(1) Findings of fact and conclusions of law, and the reasons thereof, on all issues presented; and

(2) Any terms and conditions of the ruling.
§ 2571.9

(c) A copy of any decision under this section shall be served on each party.

§ 2571.9 Decision of the administrative law judge.

For section 521 proceedings, this section shall apply in lieu of §18.57 of this title:

(a) Proposed findings of fact, conclusions, and order. Within twenty (20) days of the filing of the transcript of the testimony, or such additional time as the administrative law judge may allow, each party may file with the administrative law judge, subject to the judge’s discretion, proposed findings of fact, conclusions of law, and order together with a supporting brief expressing the reasons for such proposals. Such proposals and briefs shall be served on all parties, and shall refer to all portions of the record and to all authorities relied upon in support of each proposal.

(b) Decision of the administrative law judge. The administrative law judge shall make his or her decision expeditiously after the conclusion of the section 521 proceeding. The decision of the administrative law judge shall include findings of fact and conclusions of law with reasons therefore upon each material issue of fact or law presented on the record. The decision of the administrative law judge shall be based upon the whole record and shall be supported by reliable and probative evidence. The decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704 unless an appeal is made pursuant to the procedures set forth in §§2571.10 through 2571.12.

§ 2571.10 Review by the Secretary.

(a) The Secretary may review the decision of an administrative law judge. Such review may occur only when a party files a notice of appeal from a decision of an administrative law judge within twenty (20) days of the issuance of such a decision. In all other cases, the decision of the administrative law judge shall become final agency action within the meaning of 5 U.S.C. 704.

(b) A notice of appeal to the Secretary shall state with specificity the issue(s) in the decision of the administrative law judge on which the party is seeking review. Such notice of appeal must be served on all parties of record.

(c) Upon receipt of an appeal, the Secretary shall request the Chief Administrative Law Judge to submit to the Secretary a copy of the entire record before the administrative law judge.

§ 2571.11 Scope of review by the Secretary.

The review of the Secretary shall be based on the record established before the administrative law judge. There shall be no opportunity for oral argument.

§ 2571.12 Procedures for review by the Secretary.

(a) Upon receipt of a notice of appeal, the Secretary shall establish a briefing schedule which shall be served on all parties of record. Upon motion of one or more of the parties, the Secretary may, in her discretion, permit the submission of reply briefs.

(b) The Secretary shall issue a decision as promptly as possible after receipt of the briefs of the parties. The Secretary may affirm, modify, or set aside, in whole or in part, the decision on appeal and shall issue a statement of reasons and bases for the action(s) taken. Such decision by the Secretary shall be the final agency action with the meaning of 5 U.S.C. 704.

§ 2571.13 Effective date.

This regulation is effective with respect to all cease and desist orders issued by the Secretary under section 521 of ERISA at any time after April 1, 2013.

Subpart B [Reserved]

PART 2575—ADJUSTMENT OF CIVIL PENALTIES UNDER ERISA TITLE I

Subpart A—Adjustment of Civil Penalties Under ERISA Title I

Sec.
2575.100 In general.
2575.209b-1 Adjusted civil penalty under section 209(b).
2575.502c-1 Adjusted civil penalty under section 502(c)(1).
2575.502c-2 Adjusted civil penalty under section 502(c)(2).
§ 2575.502c–3 Adjusted civil penalty under section 502(c)(3).

§ 2575.502c–5 Adjusted civil penalty under section 502(c)(5).

§ 2575.502c–6 Adjusted civil penalty under section 502(c)(6).

Subparts B–D [Reserved]


Source: 64 FR 42246, Aug. 3, 1999, unless otherwise noted.

Subpart A—Adjustment of Civil Penalties Under ERISA Title I


§ 2575.100 In general.

Section 31001(s) of the Debt Collection Improvement Act of 1996 (the Act, Public Law 104–134, 110 Stat. 1321–373) amended the Federal Civil Penalties Inflation Adjustment Act of 1990 (the 1990 Act, Public Law 101–410, 104 Stat. 890) to require generally that the head of each Federal agency adjust the civil monetary penalties subject to its jurisdiction for inflation within 180 days after enactment of the Act and at least once every four years thereafter.

(68 FR 2878, Jan. 22, 2003)

§ 2575.209b–1 Adjusted civil penalty under section 209(b).

In accordance with the requirements of the 1990 Act, as amended, the amount of the civil monetary penalty established by section 209(b) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $30 for each employee to $35 for each employee. This adjusted penalty applies only to violations occurring after July 29, 1997.

(68 FR 2878, Jan. 22, 2003)

§ 2575.502c–1 Adjusted civil penalty under section 502(c)(1).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $100 a day to $110 a day. This adjusted penalty applies only to violations occurring after July 29, 1997.

§ 2575.502c–2 Adjusted civil penalty under section 502(c)(2).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(2) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $100 a day to $110 a day. This adjusted penalty applies only to violations occurring after July 29, 1997.

§ 2575.502c–3 Adjusted civil penalty under section 502(c)(3).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(3) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $100 a day to $110 a day. This adjusted penalty applies only to violations occurring after July 29, 1997.

§ 2575.502c–5 Adjusted civil penalty under section 502(c)(5).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(5) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $1,000 a day to $1,100 a day. This adjusted penalty applies only to violations occurring after March 24, 2003.

(68 FR 2879, Jan. 22, 2003)

§ 2575.502c–6 Adjusted civil penalty under section 502(c)(6).

In accordance with the requirements of the 1990 Act, as amended, the maximum amount of the civil monetary penalty established by section 502(c)(6) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), is hereby increased from $1,000 per request to $1,100 per request. This adjusted penalty applies only to

[68 FR 2879, Jan. 22, 2003]

Subparts B–D [Reserved]

PART 2578—RULES AND REGULATIONS FOR ABANDONED PLANS

Sec. 2578.1 Termination of abandoned individual account plans.

AUTHORITY: 29 U.S.C. 1135; 1104(a); 1103(d)(1).

§ 2578.1 Termination of abandoned individual account plans.

(a) General. The purpose of this part is to establish standards for the termination and winding up of an individual account plan (as defined in section 3(34) of the Employee Retirement Income Security Act of 1974 (ERISA or the Act)) with respect to which a qualified termination administrator (as defined in paragraph (g) of this section) has determined there is no responsible plan sponsor or plan administrator within the meaning of section 3(16)(B) and (A) of the Act, respectively, to perform such acts.

(b) Finding of abandonment. (1) A qualified termination administrator may find an individual account plan to be abandoned when:

(i) Either: (A) No contributions to, or distributions from, the plan have been made for a period of at least 12 consecutive months immediately preceding the date on which the determination is being made; or

(B) Other facts and circumstances (such as a filing by or against the plan sponsor for liquidation under title 11 of the United States Code, or communications from participants and beneficiaries regarding distributions) known to the qualified termination administrator suggest that the plan is or may become abandoned by the plan sponsor; and

(ii) Following reasonable efforts to locate or communicate with the plan sponsor, the qualified termination administrator determines that the plan sponsor:

(A) No longer exists;

(B) Cannot be located; or

(C) Is unable to maintain the plan.

(2) Notwithstanding paragraph (b)(1) of this section, a qualified termination administrator may not find a plan to be abandoned if, at any time before the plan is deemed terminated pursuant to paragraph (c) of this section, the qualified termination administrator receives an objection from the plan sponsor regarding the finding of abandonment and proposed termination.

(3) A qualified termination administrator shall, for purposes of paragraph (b)(1)(ii) of this section, be deemed to have made a reasonable effort to locate or communicate with the plan sponsor if the qualified termination administrator sends to the last known address of the plan sponsor, and, in the case of a plan sponsor that is a corporation, to the address of the person designated as the corporation’s agent for service of legal process, by a method of delivery requiring acknowledgement of receipt, the notice described in paragraph (b)(5) of this section.

(4) If receipt of the notice described in paragraph (b)(5) of this section is not acknowledged pursuant to paragraph (b)(3) of this section, the qualified termination administrator shall be deemed to have made a reasonable effort to locate or communicate with the plan sponsor if the qualified termination administrator contacts known service providers (other than itself) of the plan and requests the current address of the plan sponsor from such service providers and, if such information is provided, the qualified termination administrator sends to each such address, by a method of delivery requiring acknowledgement of receipt, the notice described in paragraph (b)(5) of this section.

(5) The notice referred to in paragraph (b)(3) of this section shall contain the following information:

(i) The name and address of the qualified termination administrator;

(ii) The name of the plan;

(iii) The account number or other identifying information relating to the plan;

(iv) A statement that the plan may be terminated and benefits distributed pursuant to 29 CFR 2578.1 if the plan sponsor fails to contact the qualified
termination administrator within 30 days;
(v) The name, address, and telephone number of the person, office, or department that the plan sponsor must contact regarding the plan;
(vi) A statement that if the plan is terminated pursuant to 29 CFR 2578.1, notice of such termination will be furnished to the U.S. Department of Labor’s Employee Benefits Security Administration;
(vii) The following statement: “The U.S. Department of Labor requires that you be informed that, as a fiduciary or plan administrator or both, you may be personally liable for costs, civil penalties, excise taxes, etc. as a result of your acts or omissions with respect to this plan. The termination of this plan will not relieve you of your liability for any such costs, penalties, taxes, etc.”; and
(viii) A statement that the plan sponsor may contact the U.S. Department of Labor for more information about the federal law governing the termination and winding-up process for abandoned plans and the telephone number of the appropriate Employee Benefits Security Administration contact person.

(c) Deemed termination. (1) Except as provided in paragraph (c)(2) of this section, if a qualified termination administrator finds, pursuant to paragraph (b)(1) of this section, that an individual account plan has been abandoned, the plan shall be deemed to be terminated on the ninetieth (90th) day following the date of the letter from EBSA’s Office of Enforcement acknowledging receipt of the notice of plan abandonment, described in paragraph (c)(3) of this section.
(2) If, prior to the end of the 90-day period described in paragraph (c)(1) of this section, the Department notifies the qualified termination administrator that it—
(i) Objects to the termination of the plan, the plan shall not be deemed terminated under paragraph (c)(1) of this section until the qualified termination administrator is notified that the Department has withdrawn its objection; or
(ii) Waives the 90-day period described in paragraph (c)(1), the plan shall be deemed terminated upon the qualified termination administrator’s receipt of such notification.
(3) Following a qualified termination administrator’s finding, pursuant to paragraph (b)(1) of this section, that an individual account plan has been abandoned, the qualified termination administrator shall furnish to the U.S. Department of Labor a notice of plan abandonment that is signed and dated by the qualified termination administrator and that includes the following information:
(i) Qualified termination administrator information. (A) The name, EIN, address, and telephone number of the person electing to be the qualified termination administrator, including the address, e-mail address, and telephone number of the person signing the notice (or other contact person, if different from the person signing the notice);
(B) A statement that the person (identified in paragraph (c)(3)(i)(A) of this section) is a qualified termination administrator within the meaning of paragraph (g) of this section and elects to terminate and wind up the plan (identified in paragraph (c)(3)(i)(A) of this section) in accordance with the provisions of this section; and
(C) An identification whether the person electing to be the qualified termination administrator or its affiliate is, or within the past 24 months has been, the subject of an investigation, examination, or enforcement action by the Department, Internal Revenue Service, or Securities and Exchange Commission concerning such entity’s conduct as a fiduciary or party in interest with respect to any plan covered by the Act.
(ii) Plan information. (A) The name, address, telephone number, account number, EIN, and plan number of the plan with respect to which the person is electing to serve as the qualified termination administrator;
(B) The name and last known address and telephone number of the plan sponsor; and
(C) The estimated number of participants in the plan;
(iii) Findings. A statement that the person electing to be the qualified termination administrator finds that the plan (identified in paragraph
§ 2578.1 29 CFR Ch. XXV (7–1–15 Edition)

(c)(3)(ii)(A) of this section) is abandoned pursuant to paragraph (b) of this section. This statement shall include an explanation of the basis for such a finding, specifically referring to the provisions in paragraph (b)(1) of this section, a description of the specific steps (set forth in paragraphs (b)(3) and (b)(4) of this section) taken to locate or communicate with the known plan sponsor, and a statement that no objection has been received from the plan sponsor;

(iv) Plan asset information. (A) The estimated value of the plan’s assets held by the person electing to be the qualified termination administrator;

(B) The length of time plan assets have been held by the person electing to be the qualified termination administrator, if such period of time is less than 12 months;

(C) An identification of any assets with respect to which there is no readily ascertainable fair market value, as well as information, if any, concerning the value of such assets; and

(D) An identification of known delinquent contributions pursuant to paragraph (d)(2)(iii) of this section;

(v) Service provider information. (A) The name, address, and telephone number of known service providers (e.g., record keeper, accountant, lawyer, other asset custodian(s)) to the plan; and

(B) An identification of any services considered necessary to wind up the plan in accordance with this section, the name of the service provider(s) that is expected to provide such services, and an itemized estimate of expenses attendant thereto expected to be paid out of plan assets by the qualified termination administrator; and

(vi) Perjury statement. A statement that the information being provided in the notice is true and complete based on the knowledge of the person electing to be the qualified termination administrator, and that the information is being provided by the qualified termination administrator under penalty of perjury.

(d) Winding up the affairs of the plan. (1) In any case where an individual account plan is deemed to be terminated pursuant to paragraph (c) of this section, the qualified termination administrator shall take steps as may be necessary or appropriate to wind up the affairs of the plan and distribute benefits to the plan’s participants and beneficiaries.

(2) For purposes of paragraph (d)(1) of this section, the qualified termination administrator shall:

(i) Update plan records. (A) Undertake reasonable and diligent efforts to locate and update plan records necessary to determine the benefits payable under the terms of the plan to each participant and beneficiary.

(B) For purposes of paragraph (d)(2)(i)(A) of this section, a qualified termination administrator shall not have failed to make reasonable and diligent efforts to update plan records merely because the administrator determines in good faith that updating the records is either impossible or involves significant cost to the plan in relation to the total assets of the plan.

(ii) Calculate benefits. Use reasonable care in calculating the benefits payable to each participant or beneficiary based on plan records described in paragraph (d)(2)(i) of this section. A qualified termination administrator shall not have failed to use reasonable care in calculating benefits payable solely because the qualified termination administrator—

(A) Treats as forfeited an account balance that, taking into account estimated forfeitures and other assets allocable to the account, is less than the estimated share of plan expenses allocable to that account, and reallocates that account balance to defray plan expenses or to other plan accounts in accordance with (d)(2)(ii)(B) of this section;

(B) Allocates expenses and unallocated assets in accordance with the plan documents, or, if the plan document is not available, is ambiguous, or if compliance with the plan is unfeasible,

(1) Allocates unallocated assets (including forfeitures and assets in a suspense account) to participant accounts on a per capita basis (allocated equally to all accounts); and

(2) Allocates expenses on a pro rata basis (proportionately in the ratio that each individual account balance bears to the total of all individual account
(iii) Report delinquent contributions. 
(A) Notify the Department of any known contributions (either employer or employee) owed to the plan in conjunction with the filing of either the notification required in paragraph (c)(3) or (d)(2)(ix) of this section.

(B) Nothing in paragraph (d)(2)(iii)(A) of this section or any other provision of the Act shall be construed to impose an obligation on the qualified termination administrator to collect delinquent contributions on behalf of the plan, provided that the qualified termination administrator satisfies the requirements of paragraph (d)(2)(iii)(A) of this section.

(iv) Engage service providers. Engage, on behalf of the plan, such service providers as are necessary for the qualified termination administrator to wind up the affairs of the plan and distribute benefits to the plan’s participants and beneficiaries in accordance with paragraph (d)(1) of this section.

(v) Pay reasonable expenses. (A) Pay, from plan assets, the reasonable expenses of carrying out the qualified termination administrator’s authority and responsibility under this section.

(B) Expenses of plan administration shall be considered reasonable solely for purposes of paragraph (d)(2)(v)(A) of this section if:

(1) Such expenses are for services necessary to wind up the affairs of the plan and distribute benefits to the plan’s participants and beneficiaries,

(2) Such expenses: (i) Are consistent with industry rates for such or similar services, based on the experience of the qualified termination administrator; and

(ii) Are not in excess of rates ordinarily charged by the qualified termination administrator (or affiliate) for same or similar services provided to customers that are not plans terminated pursuant to this section, if the qualified termination administrator (or affiliate) provides same or similar services to such other customers, and

(3) The payment of such expenses would not constitute a prohibited transaction under the Act or is exempted from such prohibited transaction provisions pursuant to section 408(a) of the Act.

(vi) Notify participants. (A) Furnish to each participant or beneficiary of the plan a notice written in a manner calculated to be understood by the average plan participant and containing the following:

(1) The name of the plan;

(2) A statement that the plan has been determined to be abandoned by the plan sponsor and, therefore, has been terminated pursuant to regulations issued by the U.S. Department of Labor;

(3)(i) A statement of the account balance and the date on which it was calculated by the qualified termination administrator, and

(ii) The following statement: “The actual amount of your distribution may be more or less than the amount stated in this letter depending on investment gains or losses and the administrative cost of terminating your plan and distributing your benefits.”;

(4) A description of the distribution options available under the plan and a request that the participant or beneficiary elect a form of distribution and inform the qualified termination administrator (or designee) of that election;

(5) A statement explaining that, if a participant or beneficiary fails to make an election within 30 days from receipt of the notice, the qualified termination administrator (or designee) will distribute the account balance of the participant or beneficiary directly:

(i) To an individual retirement plan (i.e., individual retirement account or annuity),

(ii) To an inherited individual retirement plan described in §2550.404a–3(d)(1)(ii) of this chapter (in the case of a distribution on behalf of a distributee other than a participant or spouse),

(iii) In any case where the amount to be distributed meets the conditions in §2550.404a–3 (d)(1)(iii), to an interest-bearing federally insured bank account, the unclaimed property fund of the State of the last known address of the participant or beneficiary, or an individual retirement plan (described in §2550.404a–3(d)(1)(i) or (d)(1)(ii) of this chapter) or
(iv) To an annuity provider in any case where the qualified termination administrator determines that the survivor annuity requirements in sections 401(a)(11) and 417 of the Internal Revenue Code (or section 205 of ERISA) prevent a distribution under paragraph (d)(2)(vii)(B)(1) of this section;

(6) In the case of a distribution to an individual retirement plan (described in §2550.404a–3(d)(1)(i) or (d)(1)(ii) of this chapter) a statement explaining that the account balance will be invested in an investment product designed to preserve principal and provide a reasonable rate of return and liquidity;

(7) A statement of the fees, if any, that will be paid from the participant or beneficiary’s individual retirement plan (described in §2550.404a–3(d)(1)(i) or (d)(1)(ii) of this chapter) or other account (described in §2550.404a–3(d)(1)(iii)(A) of this chapter), if such information is known at the time of the furnishing of this notice;

(8) The name, address and phone number of the provider of the individual retirement plan (described in §2550.404a–3(d)(1)(i) or (d)(1)(ii) of this chapter), qualified survivor annuity, or other account (described in §2550.404a–3(d)(1)(iii)(A) of this chapter), if such information is known at the time of the furnishing of this notice; and

(9) The name, address, and telephone number of the qualified termination administrator and, if different, the name, address and phone number of a contact person (or entity) for additional information concerning the termination and distribution of benefits under this section.

(B)(1) For purposes of paragraph (d)(2)(vi)(A) of this section, a notice shall be furnished to each participant or beneficiary in accordance with the requirements of §2530.104h–1(b)(1) of this chapter to the last known address of the participant or beneficiary; and

(2) In the case of a notice that is returned to the plan as undeliverable, the qualified termination administrator shall, consistent with the duties of a fiduciary under section 404(a)(1) of ERISA, take steps to locate and provide notice to the participant or beneficiary prior to making a distribution pursuant to paragraph (d)(2)(vii) of this section. If, after such steps, the qualified termination administrator is unsuccessful in locating and furnishing notice to a participant or beneficiary, the participant or beneficiary shall be deemed to have been furnished the notice and to have failed to make an election within the 30-day period described in paragraph (d)(2)(vii) of this section.

(vii) Distribute benefits. (A) Distribute benefits in accordance with the form of distribution elected by each participant or beneficiary with spousal consent, if required.

(B) If the participant or beneficiary fails to make an election within 30 days from the date the notice described in paragraph (d)(2)(vi) of this section is furnished, distribute benefits—

(I) In accordance with §2550.404a–3 of this chapter; or

(2) If a qualified termination administrator determines that the survivor annuity requirements in sections 401(a)(11) and 417 of the Internal Revenue Code (or section 205 of ERISA) prevent a distribution under paragraph (d)(2)(vii)(B)(1) of this section, in any manner reasonably determined to achieve compliance with those requirements.

(C) For purposes of distributions pursuant to paragraph (d)(2)(vii)(B) of this section, the qualified termination administrator may designate itself (or an affiliate) as the transferee of such proceeds, and invest such proceeds in a product in which it (or an affiliate) has an interest, only if such designation and investment is exempted from the prohibited transaction provisions under the Act pursuant to section 408(a) of the Act.

(viii) Special Terminal Report for Abandoned Plans. File the Special Terminal Report for Abandoned Plans in accordance with §2520.103–13 of this chapter.

(ix) Final Notice. No later than two months after the end of the month in which the qualified termination administrator satisfies the requirements in paragraph (d)(2)(i) through (d)(2)(vii) of this section, furnish to the Office of Enforcement, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210, a notice,
signed and dated by the qualified termination administrator, containing the following information:

(A) The name, EIN, address, e-mail address, and telephone number of the qualified termination administrator, including the address and telephone number of the person signing the notice (or other contact person, if different from the person signing the notice);

(B) The name, account number, EIN, and plan number of the plan with respect to which the person served as the qualified termination administrator;

(C) A statement that the plan has been terminated and all the plan’s assets have been distributed to the plan’s participants and beneficiaries on the basis of the best available information;

(D) A statement that plan expenses were paid out of plan assets by the qualified termination administrator in accordance with the requirements of paragraph (d)(2)(v) of this section;

(E) If fees and expenses paid to the qualified termination administrator (or its affiliate) exceed by 20 percent or more the estimate required by paragraph (c)(3)(v)(B) of this section, a statement that actual fees and expenses exceeded estimated fees and expenses and the reasons for such additional costs;

(F) An identification of known delinquent contributions pursuant to paragraph (d)(2)(iii) of this section (if not already reported under paragraph (c)(3)(iv)(D)); and

(G) A statement that the information being provided in the notice is true and complete based on the knowledge of the qualified termination administrator, and that the information is being provided by the qualified termination administrator under penalty of perjury.

(3) The terms of the plan shall, for purposes of title I of ERISA, be deemed amended to the extent necessary to allow the qualified termination administrator to wind up the plan in accordance with this section.

(e) Limited liability. (1)(i) Except as otherwise provided in paragraph (e)(2)(ii) and (iii) of this section, to the extent that the activities enumerated in paragraph (d)(2) of this section involve the exercise of discretionary authority or control that would make the qualified termination administrator a fiduciary within the meaning of section 3(21) of the Act, the qualified termination administrator shall be deemed to satisfy its responsibilities under section 404(a) of the Act with respect to such activities, provided that the qualified termination administrator complies with the requirements of paragraph (d)(2) of this section.

(ii) A qualified termination administrator shall be responsible for the selection and monitoring of any service provider (other than monitoring a provider selected pursuant to paragraph (d)(2)(vii)(B) of this section) determined by the qualified termination administrator to be necessary to the winding up of the affairs of the plan, as well as ensuring the reasonableness of the compensation paid for such services. If a qualified termination administrator selects and monitors a service provider in accordance with the requirements of section 404(a) of the Act, the qualified termination administrator shall not be liable for the acts or omissions of the service provider with respect to which the qualified termination administrator does not have knowledge.

(iii) For purposes of a distribution pursuant to paragraph (d)(2)(vii)(B)(2) of this section, a qualified termination administrator shall be responsible for the selection of an annuity provider in accordance with section 404 of the Act.

(2) Nothing herein shall be construed to impose an obligation on the qualified termination administrator to conduct an inquiry or review to determine whether or what breaches of fiduciary responsibility may have occurred with respect to a plan prior to becoming the qualified termination administrator for such plan.

(3) If assets of an abandoned plan are held by a person other than the qualified termination administrator, such person shall not be treated as in violation of section 404 (a) the Act solely on the basis that the person cooperated with and followed the directions of the qualified termination administrator in carrying out its responsibilities under this section with respect to such plan, provided that, in advance of any transfer or disposition of any assets at the
direction of the qualified termination administrator, such person confirms with the Department of Labor that the person representing to be the qualified termination administrator with respect to the plan is the qualified termination administrator recognized by the Department of Labor.

(f) Continued liability of plan sponsor. Nothing in this section shall serve to relieve or limit the liability of any person other than the qualified termination administrator due to a violation of ERISA.

(g) Qualified termination administrator. A termination administrator is qualified under this section only if:

(1) It is eligible to serve as a trustee or issuer of an individual retirement plan, within the meaning of section 7701(a)(37) of the Internal Revenue Code, and

(2) It holds assets of the plan that is considered abandoned pursuant to paragraph (b) of this section.

(h) Affiliate. (1) Except as provided in paragraph (h)(2) of this section, the term affiliate means any person directly or indirectly controlling, controlled by, or under common control with, the person; or any officer, director, partner or employee of the person.

(2) For purposes of paragraph (c)(3)(I)(C) of this section, the term affiliate means a 50 percent or more owner of a qualified termination administrator, or any person described in paragraph (h)(1) of this section that provides services to the plan.

(3) For purposes of paragraph (h)(1) of this section, the term control means the power to exercise a controlling influence over the management or policies of a person other than an individual.

(i) Model notices. Appendices to this section contain model notices that are intended to assist qualified termination administrators in discharging the notification requirements under this section. Their use is not mandatory. However, the use of appropriately completed model notices will be deemed to satisfy the requirements of paragraphs (b)(5), (c)(3), (d)(2)(v), and (d)(2)(ix) of this section.
APPENDIX A TO § 2578.1

NOTICE OF INTENT TO TERMINATE PLAN

[Date of notice]

[Name of plan sponsor]
[Last known address of plan sponsor]

Re: [Name of plan and account number or other identifying information]

Dear [Name of plan sponsor]:

We are writing to advise you of our concern about the status of the subject plan. Our intention is to terminate the plan and distribute benefits in accordance with federal law if you do not contact us within 30 days of your receipt of this notice. See 29 CFR 2578.1.

Our basis for taking this action is that our records reflect that there have been no contributions to, or distributions from, the plan within the past 12 months. (If the basis for sending this notice is under § 29 CFR 2578.1(b)(1)(i)(B), complete and include the sentence below rather than the sentence above.) Our basis for taking this action is [provide a description of the facts and circumstances indicating plan abandonment].

We are sending this notice to you because our records show that you are the sponsor of the subject plan. The U.S. Department of Labor requires that you be informed that, as a fiduciary or plan administrator or both, you may be personally liable for all costs, civil penalties, excise taxes, etc. as a result of your acts or omissions with respect to this plan. The termination of this plan by us will not relieve you of your liability for any such costs, penalties, taxes, etc. Federal law also requires us to notify the U.S. Department of Labor, Employee Benefits Security Administration, of the termination of any abandoned plan. For information about the federal law governing the termination of abandoned plans, you may contact the U.S. Department of Labor at [telephone number of appropriate EBSA contact person].

Please contact [name, address, and telephone number of the person, office, or department that the sponsor must contact regarding the plan] within 30 days in order to prevent this action.

Sincerely,

[Name and address of qualified termination administrator or appropriate designee]
NOTIFICATION OF PLAN ABANDONMENT AND INTENT TO SERVE AS QUALIFIED TERMINATION ADMINISTRATOR

[Date of notice]

Abandoned Plan Coordinator, Office of Enforcement
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Suite 600
Washington, DC, 20210

Re: Plan Identification
[Plan name and plan number]
[EIN]
[Plan account number]
[Address]
[Telephone number]

Qualified Termination Administrator
[Name]
[Address]
[E-mail address]
[Telephone number]
[EIN]

Abandoned Plan Coordinator:

Pursuant to 29 CFR 2578.1(b), we have determined that the subject plan is or may become abandoned by its sponsor. We are eligible to serve as a Qualified Termination Administrator for purposes of terminating and winding up the plan in accordance with 29 CFR 2578.1, and hereby elect to do so.

We find that [check the appropriate box below and provide additional information as necessary]:

☐ There have been no contributions to, or distributions from, the plan for a period of at least 12 consecutive months immediately preceding the date of this letter. Our records indicate that the date of the last contribution or distribution was [enter appropriate date].

☐ The following facts and circumstances suggest that the plan is or may become abandoned by the plan sponsor [add description below]:


780
We have also determined that the plan sponsor *(check appropriate box below)*:

- No longer exists
- Cannot be located
- Is unable to maintain the plan

We have taken the following steps to locate or communicate with the known plan sponsor and have received no objection *(provide an explanation below)*:

**Part I – Plan Information**

1. Estimated number of individuals (participants and beneficiaries) with accounts under the plan: *[number]*

2. Plan assets held by Qualified Termination Administrator:
   - A. Estimated value of assets: *[value]*
   - B. Months we have held plan assets, if less than 12: *[number]*
   - C. Hard to value assets *(select “yes” or “no” to identify any assets with no readily ascertainable fair market value, and include for those identified assets the best known estimate of their value)*:
     - (a) Partnership/joint venture interests  
       - Yes  
       - No  
       - [value]
     - (b) Employer real property  
       - Yes  
       - No  
       - [value]
     - (c) Real estate (other than (b))  
       - Yes  
       - No  
       - [value]
     - (d) Employer securities  
       - Yes  
       - No  
       - [value]
     - (e) Participant loans  
       - Yes  
       - No  
       - [value]
     - (f) Loans (other than (e))  
       - Yes  
       - No  
       - [value]
     - (g) Tangible personal property  
       - Yes  
       - No  
       - [value]

3. Name and last known address and telephone number of plan sponsor:

4. Other:
§ 2578.1

Part II – Known Service Providers of the Plan

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part III – Services and Related Expenses to be Paid

<table>
<thead>
<tr>
<th>Services</th>
<th>Service Provider</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Part IV – Investigation

In the past 24 months (check one box):

☐ Neither we nor our affiliates are or have been the subject of an investigation, examination, or enforcement action by the Department, Internal Revenue Service, or Securities and Exchange Commission concerning such entity’s conduct as a fiduciary or party in interest with respect to any plan covered by the Act.

☐ We or our affiliates are or have been the subject of an investigation, examination, or enforcement action by the Department, Internal Revenue Service, or Securities and Exchange Commission concerning such entity’s conduct as a fiduciary or party in interest with respect to any plan covered by the Act.

Part V – Contact Person (enter information only if different from signatory):

[Name]
[Address]
[E-mail address]
[Telephone number]

Under penalties of perjury, I declare that I have examined this notice and to the best of my knowledge and belief, it is true, correct and complete.

[Signature]
[Title of person signing on behalf the Qualified Termination Administrator]
[Address, e-mail address, and telephone number]
APPENDIX C TO § 2578.1

NOTICE OF PLAN TERMINATION

[Date of notice]

[Name and last known address of plan participant or beneficiary]

Re: [Name of plan]

Dear [Name of plan participant or beneficiary]:

We are writing to inform you that the [name of plan] (Plan) has been terminated pursuant to regulations issued by the U.S. Department of Labor. The Plan was terminated because it was abandoned by [name of the plan sponsor].

We have determined that you have an interest in the Plan, either as a plan participant or beneficiary. Your account balance on [date] is/was [account balance]. We will be distributing this money as permitted under the terms of the Plan and federal regulations. The actual amount of your distribution may be more or less than the amount stated in this letter depending on investment gains or losses and the administrative cost of terminating the Plan and distributing your benefits.

Your distribution options under the Plan are [add a description of the Plan’s distribution options]. It is very important that you elect one of these forms of distribution and inform us of your election. The process for informing us of this election is [enter a description of the election process established by the qualified termination administrator].

[Select the next paragraph from options 1 through 3, as appropriate.]

[Option 1: If this notice is for a participant or beneficiary, complete and include the following paragraph provided the account balance does not meet the conditions of §2550.404a-3(d)(1)(ii).]

If you do not make an election within 30 days from your receipt of this notice, your account balance will be transferred directly to an individual retirement plan (inherited individual retirement plan in the case of a nonspouse beneficiary) maintained by [insert the name, address, and phone number of the provider if known, other wise insert the following language [a bank or insurance company or other similar financial institution]].

Pursuant to federal law, your money in the individual retirement plan would then be invested in an investment product designed to preserve principal and provide a reasonable rate of return and liquidity. [If fee information is known, include the following sentence: Should your money be transferred into an individual retirement plan, [name of the financial institution] charges the following fees for its services: [add a statement of fees, if any, that will be paid from the participant or beneficiary’s individual retirement plan].]
§ 2578.1

{Option 2: If this notice is for a participant or beneficiary whose account balance meets the conditions of §2550.404a-3(d)(1)(iii), complete and include the following paragraph.}

If you do not make an election within 30 days from your receipt of this notice, and your account balance is $1,000 or less, federal law permits us to transfer your balance to an interest-bearing federally insured bank account, to the unclaimed property fund of the State of your last known address, or to an individual retirement plan (inherited individual retirement plan in the case of a nonspouse beneficiary). Pursuant to federal law, your money, if transferred to an individual retirement plan would then be invested in an investment product designed to preserve principal and provide a reasonable rate of return and liquidity. {If known, include the name, address, and telephone number of the financial institution or State fund into which the individual’s account balance will be transferred or deposited. If the individual’s account balance is to be transferred to a financial institution and fee information is known, include the following sentence: Should your money be transferred into a plan or account, [name of the financial institution] charges the following fees for its services: {add a statement of fees, if any, that will be paid from the individual’s account}.}

{Option 3: If this notice is for a participant’s spouse whose distribution is subject to the survivor annuity requirements in sections 401(a)(11) and 417 of the Internal Revenue Code (or section 205 of ERISA), complete and include the following paragraph.}

If you do not make an election within 30 days from your receipt of this notice, your account balance will be distributed in the form of a qualified joint and survivor annuity or qualified preretirement annuity as required by the Internal Revenue Code. {If the name of the annuity provider is known, include the following sentence: The name of the annuity provider is [name, address and phone number of the provider].}

For more information about the termination, your account balance, or distribution options, please contact [name, address, and telephone number of the qualified termination administrator and, if different, the name, address, and telephone number of the appropriate contact person].

Sincerely,

[Name of qualified termination administrator or appropriate designee]
APPENDIX D TO § 2578.1

FINAL NOTICE

[Date of notice]

Abandoned Plan Coordinator, Office of Enforcement
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave., NW
Suite 600
Washington, DC, 20210

Re: Plan Identification
[Plan name and plan number]
[Plan account number]
[EIN]

Qualified Termination Administrator
[Name]
[Address and e-mail address]
[Telephone number]
[EIN]

Abandoned Plan Coordinator:

General Information

The termination and winding-up process of the subject plan has been completed pursuant to 29 CFR 2578.1. Benefits were distributed to participants and beneficiaries on the basis of the best available information pursuant to 29 CFR 2578.1(d)(2)(i). Plan expenses were paid out of plan assets pursuant to 29 CFR 2578.1(d)(2)(v).

{Include and complete the next section, entitled “Contact Person,” only if the contact person is different from the signatory of this notice.}

Contact Person

[Name]
[Address and e-mail address]
[Telephone number]

{Include and complete the next section, entitled “Expenses Paid to Qualified Termination Administrator,” only if fees and expenses paid to the QTA (or its affiliate) exceeded by 20 percent or more the estimate required by 29 CFR 2578.1(c)(3)(v)(B).}

Expenses Paid to Qualified Termination Administrator

The actual fees and/or expenses we received in connection with winding up the Plan exceeded by {insert either: [20 percent or more] or [enter the actual percentage]} the
§ 2578.1 29 CFR Ch. XXV (7–1–15 Edition)

estimate required by 29 CFR 2578.1(c)(3)(v)(B). The reason or reasons for such additional costs are {provide an explanation of the additional costs}.

Other

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Under penalties of perjury, I declare that I have examined this notice and to the best of my knowledge and belief, it is true, correct and complete.

[Signature]
[Title of person signing on behalf the Qualified Termination Administrator]
[Address, e-mail address, and telephone number]

Attachment


SUBCHAPTER H [RESERVED]
SUBCHAPTER I—TEMPORARY BONDING RULES UNDER THE
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

PART 2580—TEMPORARY BONDING
RULES

Subpart A—Criteria for Determining Who
Must Be Bonded
Sec. 2580.412–1 Statutory provisions.
2580.412–2 Plans exempt from the coverage of
section 13.
2580.412–3 Plan administrators, officers and
employees for purposes of section 13.
2580.412–4 “Funds or other property” of a
plan.
2580.412–5 Determining when “funds or
other property” belong to a plan.
2580.412–6 Determining when “funds or
other property” are “handled” so as to
require bonding.

Subpart B—Scope and Form of the Bond
2580.412–7 Statutory provision—scope of the
bond.
2580.412–8 The nature of the duties or activi-
ties to which the bonding requirement
relates.
2580.412–9 Meaning of fraud or dishonesty.
2580.412–10 Individual or schedule or blanket
form of bonds.

Subpart C—Amount of the Bond
2580.412–11 Statutory provision.
2580.412–12 Relationship of determining the
amount of the bond to “handling”.
2580.412–13 The meaning of “funds” in deter-
miming the amount of the bond.
2580.412–14 Determining the amount of
funds “handled” during the preceding re-
porting year.
2580.412–15 Procedures to be used for esti-
mating the amount of funds to be “han-
dled” during the current reporting year
in those cases where there is no pre-
ceding reporting year.
2580.412–16 Amount of bond required in
given types of bonds or where more than
one plan is insured in the same bond.
2580.412–17 Bonds over $500,000.

Subpart D—General Bond Rules
2580.412–18 Naming of insureds.
2580.412–19 Term of the bond, discovery pe-
riod, other bond clauses.
2580.412–20 Use of existing bonds, separate
bonds and additional bonding.

Subpart E—Qualified Agents, Brokers and
Surety Companies for the Placing of Bonds
2580.412–21 Corporate sureties holding
grants of authority from the Secretary of
the Treasury.
2580.412–22 Interests held in agents, brokers
and surety companies.

Subpart F—Exemptions
BONDS PLACED WITH CERTAIN REINSURING
COMPANIES
2580.412–23 Exemption.
2580.412–24 Conditions of exemption.
BONDS PLACED WITH UNDERWRITERS AT
LLOYDS, LONDON
2580.412–25 Exemption.
2580.412–26 Conditions of exemption.
BANKING INSTITUTIONS SUBJECT TO FEDERAL
REGULATION
2580.412–27 Exemption.
2580.412–28 Conditions of exemption.
SAVINGS AND LOAN ASSOCIATIONS SUBJECT TO
FEDERAL REGULATION
2580.412–29 Exemption.
2580.412–30 Conditions of exemption.
INSURANCE CARRIERS, SERVICE AND OTHER
SIMILAR ORGANIZATIONS
2580.412–31 Exemption.
2580.412–32 Conditions of exemption.

Subpart G—Prohibition Against Bonding by
Parties Interested in the Plan
2580.412–33 Introductory statement.
2580.412–34 General.
2580.412–35 Disqualification of agents, bro-
kers and sureties.
2580.412–36 Application of 13(c) to “party in
interest”.

894 (29 U.S.C. 1135); sec. 412(e), Pub. L. 93–406,

SOURCE: 28 FR 14403, Dec. 27, 1963, unless
otherwise noted. Redesignated at 50 FR 26706,
Subpart A—Criteria for Determining Who Must Be Bonded

§2580.412–1  Statutory provisions.

Section 13(a) of the Welfare and Pension Plans Disclosure Act of 1958, as amended, states, in part, that:

Every administrator, officer and employee of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handles funds or other property of such plan shall be bonded as herein provided; except that, where such plan is one under which the only assets from which benefits are paid are the general assets of a union or of an employer, the administrator, officers and employees of such plan shall be exempt from the bonding requirements of this section.

* * * Such bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of such administrator, officer, or employee, directly or through connivance with others.

§2580.412–2  Plans exempt from the coverage of section 13.

Only completely unfunded plans in which the plan benefits derive solely from the general assets of a union1 or employer, and in which plan assets are not segregated in any way from the general assets of a union or employer and remain solely within the general assets until the time of distribution of benefits, shall be exempt from the bonding provisions. As such, the language "where such plan is one under which the only assets from which benefits are paid are the general assets of a union or of an employer" shall not be deemed to exempt a plan from the coverage of section 13 if the plan is one in which:

(a) Any benefits thereunder are provided or underwritten by an insurance carrier or service or other organization, or

(b) There is a trust or other separate entity to which contributions are made or out of which benefits are paid, or

(c) Contributions to the plan are made by the employees, either through withholding or otherwise, or from any source other than the employer or union involved, or

(d) There is a separately maintained bank account or separately maintained books and records for the plan or other evidence of the existence of a segregated or separately maintained or administered fund out of which plan benefits are to be provided.

As a general rule, the presence of special ledger accounts or accounting entries for plan funds as an integral part of the general books and records of an employer or union shall not, in and of itself, be deemed sufficient evidence of segregation of plan funds to take a plan out of the exempt category, but shall be considered along with the other factors and criteria discussed above in determining whether the exemption applies. Again, it should be noted, however, that the fact that a plan is not exempt from the coverage of section 13 does not necessarily mean that its administrators, officers or employees are required to be bonded. As stated previously, this will depend in each case on whether or not they "handle" funds or other property of the plan within the meaning of section 13 and under the standards set forth in §2580.412–6.

§2580.412–3  Plan administrators, officers and employees for purposes of section 13.

(a) Administrator. (1) For purposes of the bonding provisions, the term "administrator" is defined in the same manner as under section 5 of the Act and refers to:

(i) The person or persons designated by the terms of the plan or the collective bargaining agreement with responsibility for the ultimate control, disposition, or management of the money received or contributed; or

(ii) In the absence of such designation, the person or persons actually responsible for the control, disposition, or management of the money received or contributed, irrespective of whether

---

1For purposes of the exemption discussed in §2580.412–2, the term “union” shall include any organization of any kind or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose in whole or in part of dealing with employers concerning an employee welfare or pension benefit plan, or other matters incidental to employment relationships (29 U.S.C. 302(a)(4)).
such control, disposition, or management is exercised directly or through an agent or trustee designated by such person or persons.

(2) Where by virtue of this definition, or regulations, interpretations or opinions issued with respect thereto, the term embodies natural persons such as members of the board of trustees of a trust, the bonding requirements shall apply to such persons.

(3) However, when by virtue of this definition or regulations, interpretations, or opinions issued with respect thereto, the administrator in a given case in an entity such as a partnership, corporation, mutual company, joint stock company, trust, unincorporated organization, union or employees' beneficiary association, the term shall be deemed to apply, in meeting the bonding requirements, only to those natural persons who:

(i) Are vested under the authority of the entity-administrator with the responsibility for carrying out functions constituting control, disposition or management of the money received or contributed within the definition of administrator, or who, acting on behalf of or under the actual or apparent authority of the entity-administrator, actually perform such functions, and who

(ii) "Handle" funds or other property of the plan within the meaning of these regulations.

(b) Officers. For purposes of the bonding provisions, the term "officer" shall include any person designated by the terms of a plan or collective bargaining agreement as an officer, any person performing or authorized to perform executive functions of the plan or any member of a board of trustees or similar governing body of a plan. The term shall include such persons regardless of whether they are representatives of or selected by an employer, employees or an employee organization. In its most frequent application the term will encompass those natural persons appointed or elected as officers of the plan or as members of boards or committees performing executive or supervisory functions for the plan, but who do not fall within the definition of administrator.

(c) Employees. For purposes of the bonding provisions the term "employee" shall, to the extent a person performs functions not falling within the definition of officer or administrator, include any employee who performs work for or directly related to a covered plan, regardless of whether technically he is employed, directly or indirectly, by or for a plan, a plan administrator, a trust, or by an employee organization or employer within the meaning of section 3(3) or 3(4) of the Act.

(d) Other persons covered. For purposes of the bonding provisions, the terms "administrator, officer, or employee" shall include any persons performing functions for the plan normally performed by administrators, officers, or employees of a plan. As such, the terms shall include persons indirectly employed, or otherwise delegated, to perform such work for the plan, such as pension consultants and planners, and attorneys who perform "handling" functions within the meaning of §2580.412–6. On the other hand, the terms would not include those brokers or independent contractors who have contracted for the performance of functions which are not ordinarily carried out by the administrators, officers, or employees of a plan, such as securities, brokers who purchase and sell securities or armored motor vehicle companies.

§2580.412–4 “Funds or other property” of a plan.

The affirmative requirement for bonding persons falling within the definition of administrator, officer or employee is applicable only if they handle "funds or other property" of the plan concerned. The term "funds or other property" is intended to encompass all property which is used or may be used as a source for the payment of benefits to plan participants. It does not include permanent assets used in the operation of the plan such as real property, furniture and fixtures or office and delivery equipment used in the operation of the plan. It does include all items in the nature of quick assets,
such as cash, checks and other negotiable instruments, government obligations and marketable securities. It also includes all other property or items convertible into cash or having a cash value and held or acquired for the ultimate purpose of distribution to plan participants or beneficiaries. In the case of a plan which has investments, this would include all the investments of the plan even though not in the nature of quick assets, such as land and buildings, mortgages, and securities in closely held corporations. However, in a given case, the question of whether a person was “handling” such “funds or other property” so as to require bonding would depend on whether his relationship to this property was such that there was a risk that he, alone or in connivance with others, could cause a loss of such “funds or other property” through fraud or dishonesty.

§ 2580.412–5 Determining when “funds or other property” belong to a plan.

With respect to any contribution to a plan from any source, including employers, employees or employee organizations, the point at which any given item or amount becomes “funds or other property” of a plan for purposes of the bonding provisions shall be determined as described in this section.

(a) Where the plan administrator is a board of trustees, person or body other than the employer or employee organization establishing the plan, a contribution to the plan from any source shall become “funds or other property” of the plan at the time it is received by the plan administrator. Employee contributions collected by an employer and later turned over to the plan administrator would not become “funds or other property” of the plan until receipt by the plan administrator.

(b) Where the employer or employee organization establishing the plan is itself the plan administrator:

(1) Contributions from employees or other persons who are plan participants would normally become “funds or other property” of the plan at the time they are received by the employer or employee organization, except however that contributions made by withholdings from employees’ salaries shall not be considered “funds or other property” of the plan for purposes of the bonding provisions so long as they are retained in and not segregated in any way from the general assets of the withholding employer or employee organization.

(2) Contributions made to a plan by such employer or employee organization and contributions made by withholdings from employees’ salaries would normally become “funds or other property” of the plan if and when they are taken out of the general assets of the employer or employee organization and placed in a special bank account or investment account; or identified on a separate set of books and records; or paid over to a corporate trustee or used to purchase benefits from an insurance carrier or service or other organization; or otherwise segregated, paid out or used for plan purposes, whichever shall occur first. Thus, if a plan is operated by a corporate trustee and no segregation from general assets is made of monies to be turned over to the corporate trustee prior to the actual transmittal of such monies, the contribution represented in the transmission becomes “funds or other property” of the plan at the time of receipt by the corporate trustee. On the other hand, if a special fund is first established from which monies are paid over to the corporate trustee, a given item would become “funds or other property” of the plan at the time it is placed in the special fund. Similarly, if plan benefits are provided through the medium of an insurance carrier or service or other organization and no segregation from general assets of monies used to purchase such benefits is made prior to turning such monies over to the organization contracting to provide benefits, plan funds or other property come into being at the time of receipt of payment for such benefits by the insurance carrier or service or other organization. In such a case, the “funds or other property” of the plan would be represented by the insurance contract or other obligations to pay benefits and would not be normally subject to “handling”. Bonding would not be required for any person with respect to the purchase of such benefits directly from general assets nor with respect to
the bare existence of the contract obligation to pay benefits. However, if the particular arrangement were such that monies derived from, or by virtue of, the contract did subsequently flow back to the plan, bonding may be required if such monies returning to the plan are handled by plan administrators, officers or employees. (Further discussion on bonding of insured plans is contained in §2580.412–6(b)(7)).

§2580.412–6 Determining when “funds or other property” are “handled” so as to require bonding.

(a) General scope of term. (1) A plan administrator, officer, or employee shall be deemed to be “handling” funds or other property of a plan, so as to require bonding under section 13, whenever his duties or activities with respect to given funds or other property are such that there is a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of such person, acting alone or in collusion with others. While ordinarily, those plan administrators, officers and employees who “handle” within the meaning of section 13 will be those persons with duties related to the receipt, safekeeping and disbursement of funds, the scope of the term “handles” and the prohibitions of paragraph (b) of section 13 shall be deemed to encompass any relationship of an administrator, officer or employee with respect to funds or other property which can give rise to a risk of loss through fraud or dishonesty. This shall include relationships such as those which involve access to funds or other property or decisionmaking powers with respect to funds or property which can give rise to such risk of loss.

(2) Section 13 contains no exemptions based on the amount or value of funds or other property “handled”, nor is the determination of the existence of risk of loss based on the amount involved. However, regardless of the amount involved, a given duty or relationship to funds or other property shall not be considered “handling”, and bonding is not required, where it occurs under conditions and circumstances in which the risk that a loss will occur through fraud or dishonesty is negligible. This may be the case where the risk of mishandling is precluded by the nature of the funds or other property (e.g., checks, securities or title papers which can not be negotiated by the persons performing duties with respect to them). It may also be the case where significant risk of mishandling in the performance of duties of an essentially clerical character is precluded by fiscal controls.

(b) General criteria for determining “handling”. Subject to the application of the basic standard of risk of loss to each situation, general criteria for determining whether there is “handling” so as to require bonding are:

(1) Physical contact. Physical contact with cash, checks or similar property generally constitutes “handling”. However, persons who from time to time perform counting, packaging, tabulating, messenger or similar duties of an essentially clerical character involving physical contact with funds or other property would not be “handling” when they perform these duties under conditions and circumstances where risk of loss is negligible because of factors such as close supervision and control or the nature of the property.

(2) Power to exercise physical contact or control. Whether or not physical contact actually takes place, the power to secure physical possession of cash, checks or similar property through factors such as access to a safe deposit box or similar depository, access to cash or negotiable assets, powers of custody or safekeeping, power to withdraw funds from a bank or other account generally constitutes “handling”, regardless of whether the person in question has specific duties in these matters and regardless of whether the power or access is authorized.

(3) Power to transfer to oneself or a third party or to negotiate for value. With respect to property such as mortgages, title to land and buildings, or securities, while physical contact or the possibility of physical contact may not, of itself, give rise to risk of loss so as to constitute “handling”, a person shall be regarded as “handling” such items where he, through actual or apparent authority, can cause those items to be transferred to himself or to a third party or to be negotiated for value.
(4) Disbursement. Persons who actually disburse funds or other property, such as officers or trustees authorized to sign checks or other negotiable instruments, or persons who make cash disbursements, shall be considered to be “handling” such funds or property. Whether other persons who may influence, authorize or direct disbursements or the signing or endorsing of checks or similar instruments will be considered to be “handling” funds or other property shall be determined by reference to the particular duties or responsibilities of such persons as applied to the basic criteria of risk of loss.

(5) Signing or endorsing checks or other negotiable instruments. In connection with disbursements or otherwise, any persons with the power to sign or endorse checks or similar instruments or otherwise render them transferable, whether individually or as co-signers with one or more persons, shall each be considered to be “handling” such funds or other property.

(6) Supervisory or decision making responsibility. To the extent a person’s supervisory or decision making responsibility involves factors in relationship to funds discussed in paragraph (b)(1), (2), (3), (4), or (5) of this section, such persons shall be considered to be “handling” in the same manner as any person to whom the criteria of those paragraphs apply. To the extent that only general responsibility for the conduct of the business affairs of the plan is involved, including such functions as approval of contracts, authorization of disbursements, auditing of accounts, investment decisions, determination of benefit claims and similar responsibilities, such persons shall be considered to be “handling” whenever the facts of the particular case raise the possibility that funds or other property of the plan are likely to be lost in the event of their fraud or dishonesty. The mere fact of general supervision would not necessarily, in and of itself, mean that such persons are “handling.” Factors to be accorded weight are the system of fiscal controls, the closeness and continuity of supervision, who is in fact charged with, or actually exercising final responsibility for determining whether specific disbursements, investments, contracts, or benefit claims are bona fide, regular and made in accordance with the applicable trust instrument or other plan documents.

(i) For example, persons having supervisory or decisionmaking responsibility would be “handling” to the extent they:

(a) Act in the capacity of plan “administrator” and have ultimate responsibility for the plan within the meaning of the definition of “administrator” (except to the extent that it can be shown that such persons could not, in fact, cause a loss to the plan to occur through fraud or dishonesty);

(b) Exercise close supervision over corporate trustees or other parties charged with dealing with plan funds or other property; exercise such close control over investment policy that they, in effect, determine all specific investments;

(c) Conduct, in effect, a continuing daily audit of the persons who “handle” funds;

(d) Regularly review and have veto power over the actions of a disbursing officer whose duties are essentially ministerial.

(ii) On the other hand, persons having supervisory or decisionmaking responsibility would not be “handling” to the extent:

(a) They merely conduct a periodic or sporadic audit of the persons who “handle” funds;

(b) Their duties with respect to investment policy are essentially advisory;

(c) They make a broad general allocation of funds or general authorization of disbursements intended to permit expenditures by a disbursing officer who has final responsibility for determining the propriety of any specific expenditure and making the actual disbursement;

(d) A bank or corporate trustee has all the day to day functions of administering the plan;

(e) They are in the nature of a Board of Directors of a corporation or similar authority acting for the corporation rather than for the plan and do not perform specific functions with respect to the operations of the plan.

(7) Insured plan arrangements. In many cases, plan contributions made
by employers or employee organizations or by withholding from employee's salaries are not segregated from the general assets of the employer or employee organization until payment for purchase of benefits from an insurance carrier or service or other organization. No bonding is required with respect to the payment of premiums or other payments made to purchase such benefits directly from general assets, nor with respect to the bare existence of the contract obligation to pay benefits. Such arrangements would not normally be subject to bonding except to the extent that monies returned by way of benefit payments, cash surrender, dividends, credits or otherwise, and which by the terms of the plan belonged to the plan (rather than to the employer, employee organization, insurance carrier or service or other organization) were subject to “handling” by plan administrators, officers or employees.

Subpart B—Scope and Form of the Bond

§ 2580.412–7 Statutory provision—scope of the bond.

The statute requires that the bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of a plan administrator, officer, or employee, directly or through connivance with others.

§ 2580.412–8 The nature of the duties or activities to which the bonding requirement relates.

The bond required under section 13 is limited to protection for those duties and activities from which loss can arise through fraud or dishonesty. It is not required to provide the same scope of coverage that is required in faithful discharge of duties bonds under the Labor-Management Reporting and Disclosure Act of 1959 or in the faithful performance bonds of public officials.

§ 2580.412–9 Meaning of fraud or dishonesty.

The term “fraud or dishonesty” shall be deemed to encompass all those risks of loss that might arise through dishonest or fraudulent acts in handling of funds as delineated in § 2580.412–6. As such, the bond must provide recovery for loss occasioned by such acts even though no personal gain accrues to the person committing the act and the act is not subject to punishment as a crime or misdemeanor, provided that within the law of the state in which the act is committed, a court would afford recovery under a bond providing protection against fraud or dishonesty. As usually applied under state laws, the term “fraud or dishonesty” encompasses such matters as larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, wrongful conversion, willful misapplication or any other fraudulent or dishonest acts. For the purposes of section 13, other fraudulent or dishonest acts shall also be deemed to include acts where losses result through any act or arrangement prohibited by title 18, section 1954 of the U.S. Code.

§ 2580.412–10 Individual or schedule or blanket form of bonds.

Section 13 provides that “any bond shall be in a form or of a type approved by the Secretary, including individual bonds or schedule or blanket forms of bonds which cover a group or class”. Any form of bond which may be described as individual, schedule or blanket in form or any combination of such forms of bonds shall be acceptable to meet the requirements of section 13, provided that in each case, the form of the bond, in its particular clauses and application, is not inconsistent with meeting the substantive requirements of the statute for the persons and plan involved and with meeting the specific requirements of the regulations in this part. Basic types of bonds in general usage are:

(a) Individual bond. Covers a named individual in a stated penalty.

(b) Name schedule bond. Covers a number of named individuals in the respective amounts set opposite their names.

(c) Position schedule bond. Covers each of the occupants of positions listed in the schedule in the respective amounts set opposite such positions.

(d) Blanket bonds. Cover all the insured’s officers and employees with no schedule or list of those covered being necessary and with all new officers and
employees bonded automatically, in a blanket penalty which takes two forms—an aggregate penalty bond and a multiple penalty bond which are described below:

(1) The aggregate penalty blanket bond such as the Commercial Blanket Bond; the amount of the bond is available for dishonesty losses caused by persons covered thereunder or losses in which such person is concerned or implicated. Payment of loss on account of any such person does not reduce the amount of coverage available for losses other than those caused by such person or in which he was concerned or implicated.

(2) The multiple penalty bond such as the Blanket Position Bond giving separate coverage on each person for a uniform amount—the net effect being the same as though a separate bond were issued on each person covered thereunder and all of such bonds being for a uniform amount.

NOTE: For the purpose of section 13, blanket bonds which are either aggregate penalty or multiple penalty in form shall be permissible if they otherwise meet the requirements of the Act and the regulations in this part.

Bonding, to the extent required, of persons indirectly employed, or otherwise delegated, to perform functions for the plan which are normally performed by ‘‘administrators, officers, or employees’’ as described in §2580.412–3(d) may be accomplished either by including them under individual or schedule bonds or other forms of bonds meeting the requirements of the Act, or naming them in what is known under general trade usage as an ‘‘Agents Rider’’ attached to a Blanket Bond.

Subpart C—Amount of the Bond

§ 2580.412–11 Statutory provision.

Section 13 requires that the amount of the bond be fixed at the beginning of each calendar, policy or other fiscal year, as the case may be, which constitutes the reporting year of the plan for purposes of the reporting provisions of the Act. The amount of the bond shall be not less than 10 per centum of the amount of funds handled, except that any such bond shall be in at least the amount of $1,000 and no such bond shall be required in an amount in excess of $500,000: Provided, That the Secretary, after due notice and opportunity for hearing to all interested parties, and after consideration of the record, may prescribe an amount in excess of $500,000, which in no event shall exceed 10 per centum of the funds handled. For purposes of fixing the amount of such bond, the amount of funds handled shall be determined by the funds handled by the person, group, or class to be covered by such bond and by their predecessor or predecessors, if any, during the preceding reporting year, or if the plan has no preceding reporting year, or if the plan has no preceding reporting year, the amount of funds to be handled during the current reporting year by such person, group, or class, estimated as provided in the regulations in this part. With respect to persons required to be bonded, section 13 shall be deemed to require the bond to insure from the first dollar of loss up to the requisite bond amount and not to permit the use of deductible or similar features whereby a portion of the risk within such requisite bond amount is assumed by the insured. Any request for variance from these requirements shall be made pursuant to the provisions of section 13(e) of the Act.

§ 2580.412–12 Relationship of determining the amount of the bond to ‘‘handling’’.

A determination of whether persons falling within the definition of administrator, officer or employee are required to be bonded depends on whether they ‘‘handle’’ funds or other property. Determining the amount of the bond is an aspect of the same process in that it requires a determination of what funds or other property are being handled or what amounts of funds or other property are subject to risk of loss with respect to the duties or powers of an administrator, officer or employee of a covered plan. Once this calculation is made, the required amount for which that person must be covered by a bond, either by himself or as a part of a group or class being bonded under a blanket or schedule bond, is not less than 10 percent of the amount ‘‘handled’’ or $1,000, whichever is the greater amount, except that no such
bond shall be required in an amount greater than $500,000 by virtue of these regulations. (See § 2580.412–17.)

§ 2580.412–13 The meaning of “funds” in determining the amount of the bond.

The amount of the bond depends on the amount of “funds” “handled”, and shall be sufficient to provide bonding protection against risk of loss through fraud or dishonesty for all plan funds, including other property similar to funds or in the nature of funds. As such, the term “funds” shall be deemed to include and be equivalent to “funds and other property” of the plan as described in § 2580.412–4. With respect to any item of “funds or other property” which does not have a cash or readily ascertainable market value, the value of such property may be estimated on such basis as will reasonably reflect the loss the plan might suffer if it were mishandled.

§ 2580.412–14 Determining the amount of funds “handled” during the preceding reporting year.

(a) The amount of funds “handled” by each person falling within the definition of administrator, officer, or employee (or his predecessors) during the preceding reporting year shall be the total of funds subject to risk of loss, within the meaning of the definition of “handling” (see § 2580.412–6), through acts of fraud or dishonesty, directly or in connivance with others, by such person or his predecessors during the preceding reporting year. The relationship of the determination of the amount of funds “handled” to the determination of who is “handling” can best be illustrated by a situation that commonly arises with respect to executive personnel of a plan, where a bank or corporate trustee has the responsibility for the receipt, safekeeping, physical handling and investment of a plan’s assets and the basic function of the executive personnel is to authorize payments to beneficiaries and payments for services to the corporate trustee, the actuary and the employees of the plan itself. Normally, in any given year, only a small portion of the plan’s total assets is disbursed, and the question arises as to whether an administrator or executive personnel are “handling” only the amounts actually disbursed each year or whether they are “handling” the total amounts of the assets. The answer to this question depends on the same basic criterion that governs all questions of “handling”, namely, the possibility of loss. If the authorized duties of the persons in question are strictly limited to disbursements of benefits and payments for services, and the fiscal controls and practical realities of the situation are such that these persons cannot gain access to funds which they are not legitimately allowed to disburse, the amount on which the bond is based may be limited to the amount actually disbursed in the reporting year. This would depend, in part, on the extent to which the bank or corporate trustee which has physical possession of the funds also has final responsibility for questioning and limiting disbursements from the plan, and on whether this responsibility is embodied in the original plan instruments. On the other hand, where insufficient fiscal controls exist so that the persons involved have free access to, or can obtain control of, the total amount of the fund, the bond shall reflect this fact and the amount “handled” shall be based on the total amount of the fund. This would generally occur with respect to persons such as the “administrator”, regardless of what functions are performed by a bank or corporate trustee, since the “administrator” by definition retains ultimate power to revoke any arrangement with a bank or corporate trustee. In such case, the “administrator” would have the power to commit the total amount of funds involved to his control, unless the plan itself or other specific agreement (1) prevents the “administrator” from so doing or (2) requires that revocation cannot be had unless a new agreement providing for similar controls and limitations on the “handling” of funds is simultaneously entered into.

(b) Where the circumstances of “handling” are such that the total amount of a given account or fund is subject to “handling”, the amount “handled” shall include the total of all such funds on hand at the beginning of
the reporting year, plus any items received during the year for any reason, such as contributions or income, or items received as a result of sales, investments, reinvestment, interest or otherwise. It would not, however, be necessary to count the same item twice in arriving at the total funds “handled” by a given person during a reporting year. For example, a given person may have various duties or powers involving receipt, safekeeping or disbursement of funds which would place him in contact with the same funds at several times during the same year. Different duties, however, would not make it necessary to count the same item twice in arriving at the total “handled” by him. Similarly, where a person has several different positions with respect to a plan, it would not be necessary to count the same funds each time that they are “handled” by him in these different positions, so long as the amount of the bond is sufficient to meet the 10 percent requirement with respect to the total funds “handled” by him subject to risk or loss through fraud or dishonesty, whether acting alone or in collusion with others. In general, once an item properly within the category of “funds” has been counted as “handled” by a given person, it need not be counted again even though it should subsequently be “handled” by the same person during the same year.

§ 2580.412–15 Procedures to be used for estimating the amount of funds to be “handled” during the current reporting year in those cases where there is no preceding reporting year.

If for any reason a plan does not have a complete preceding reporting year, the amount “handled” by persons required to be covered by a bond shall be estimated at the beginning of the calendar, policy or other fiscal year, as the case may be, which would constitute either the operating year or the reporting year of the plan, whichever shall occur first, as follows:

(a) In the case of a plan having a previous experience year, even though it has no preceding reporting year, the estimate of the amount to be “handled” for any person required to be covered shall be based on the experience in the previous year by applying the same standards and criteria as in a plan which has a preceding reporting year. Similarly, where a plan is recently established, but has had, at the time a bond is obtained, sufficient experience to reasonably estimate a complete year’s experience for persons required to be bonded, the amount of funds to be “handled” shall be projected to the complete year on the basis of the period in which the plan has had experience, unless, to the knowledge of the plan administrator, the period of experience is so seasonal or unrepresentative of the complete year’s experience as not to provide a reasonable basis for projecting the estimate for the complete year.

(b) Where a plan does not have any prior experience sufficient to allow it to estimate the amount “handled” in the manner outlined in paragraph (a) of this section, the amount to be “handled” by the administrators, officers and employees of the plan during the current reporting year shall be that amount initially required to fund or set up the plan, plus the amount of contributions required to be made under the plan formula from any source during the current reporting year. In most cases, the amount of contributions will be calculated by multiplying the total yearly contribution per participant (required by the plan formula from either employers, employees, employer organizations or any other source) by the number of participants in the plan at the beginning of such reporting year. In cases where the per capita contribution cannot readily be determined, such as in the case of certain insured plans covered by the Act, the amount of contributions shall be estimated on the amount of insurance premiums which are actuarially estimated as necessary to support the plan, or on such other actuarially estimated basis as may be applicable. In the case of a newly formed profit-sharing plan covered by the Act, if the employer establishing the plan has a previous year of experience, the amount of contributions required by the plan formula shall be estimated on the amount of insur-
Employee Benefits Security Admin., Labor § 2580.412–16

not more than $500,000. A bond for such amount shall be obtained in any form the plan desires on all persons who are administrators, officers, or employees of the plan and who “handle” funds or other property of the plan.

§ 2580.412–16 Amount of bond required in given types of bonds or where more than one plan is insured in the same bond.

(a) As indicated in § 2580.412–10, the Act permits the use of blanket, schedule and individual forms of bonds so long as the amount of the bond penalty is sufficient to meet the requirements of the Act for any person who is an administrator, officer or employee of a plan handling funds or other property of the plan. Such person must be bonded for 10 percent of the amount he handles, and the amount of the bond must be sufficient to indemnify the plan for any losses in which such person is involved up to that amount.

(b) When individual or schedule bonds are written, the bond amount for each person must represent not less than 10 percent of the funds “handled” by the named individual or by the person in the position. When a blanket bond is written, the amount of the bond shall be at least 10 percent of the highest amount handled by any administrator, officer or employee to be covered under the bond. It should also be noted that if an individual or group or class covered under a blanket bond “handle” a large amount of funds or other property, while the remaining bondable persons “handle” only a smaller amount, it is permissible to obtain a blanket bond in an amount sufficient to meet the 10 percent requirements for all except the individual, group or class “handling” the larger amounts, with respect to whom excess indemnity shall be secured in an amount sufficient to meet the 10 percent requirement.

(c) The Act does not prohibit more than one plan from being named as insured under the same bond. However, any such bond must allow for recovery by each plan in an amount at least equal to that which would be required if bonded separately. This requirement has application where a person or persons sought to be bonded pursuant to the requirements of section 13 have “handling” functions in more than one plan covered under the bond. Where such is the case, the amount of the bond must be sufficient to cover any such persons having functions in more than one plan for at least 10 percent of the total amount “handled” by them in all the plans covered under the bond. For example, X is the administrator of two welfare plans run by the same employer and he “handled” $100,000 in the preceding reporting year for Plan A and $500,000 in the preceding reporting year for Plan B. If both plans are covered under the same bond, the amount of the bond with respect to X shall be at least $60,000 or ten percent of the total “handled” by X for both plans covered under the bond in which X has powers and duties of “handling” since Plan B is required to carry bond in at least the amount of $50,000 and Plan A, $10,000.

(d) Additionally, in order to meet the requirement that each plan be protected, it shall be necessary that arrangement be made either by the terms of the bond or rider to the bond or by separate agreement among the parties concerned, that payment of a loss sustained by one of such insureds shall not work to the detriment of any other plan covered under the bond with respect to the amount for which that plan is required to be covered. For example, if Plan A suffered a loss of $30,000 as described above and such loss was recompensed in its entirety by the surety company, it would receive $20,000 more than the $10,000 protection required under section 13, and only $30,000 would be available for recovery with respect to further losses caused by X. In a subsequently discovered defalcation of $40,000 by X from Plan B, it would be necessary that the bond, rider, or separate agreement provide that such amount of recovery paid to Plan A in excess of the $10,000 for which it is required to be covered, be made available by such insured to, or held for the use of, Plan B in such amount as Plan B would receive if bonded separately. Thus, in the instant case, Plan B would be able to recover the full $40,000 of its loss. Where the funds or other property of several plans are commingled (if permitted by law) with each other or with other funds,
§ 2580.412–17 Bonds over $500,000.

The Labor-Management Services Administrator, after due notice and opportunity for hearing to all interested parties, and after consideration of the record, may prescribe an amount in excess of $500,000, which in no event shall exceed 10 per centum of the funds “handled.” Any requirement for bonding in excess of $500,000 shall be according to such other regulations as may be prescribed.

Subpart D—General Bond Rules

§ 2580.412–18 Naming of insureds.

Since section 13 is intended to protect funds or other property of all plans involved, bonds under this section shall allow for enforcement or recovery by those persons usually authorized to act for such plans in such matters. In most cases, the naming of the plan or plans as insured will provide for such recovery. Where it is not clear that such recovery will be provided, however, a rider shall be attached to the bond or separate agreement made among the parties concerned to make certain that any reimbursement collected under the bond will be for the benefit and use of the plan suffering a loss. Such rider or agreement shall always be required as respects any bond (a) where the employer or employee organization is first named joint insured with one or more plans, or (b) two or more plans are named joint insureds under a single bond with the first named acting for all insureds for the purpose of orderly servicing of the bond.

§ 2580.412–19 Term of the bond, discovery period, other bond clauses.

(a) Term of the bond. The amount of any required bond must in each instance be based on the amount of funds “handled” and must be fixed or estimated at the beginning of the plan’s reporting year, that is, as soon after the date when such year begins as the necessary information from the preceding reporting year can practicably be ascertained. This does not mean, however, that a new bond must be obtained each year. There is nothing in the Act that prohibits a bond for a term longer than one year, with whatever advantages such a bond might offer by way of a lower premium. However, at the beginning of each reporting year the bond shall be in at least the requisite amount. If, for any reason, the bond is below the required level at that time, the existing bond shall either be increased to the proper amount, or a supplemental bond shall be obtained.

(b) Discovery period. A discovery period of no less than one year after the termination or cancellation of the bond is required. Any standard form written on a “discovery” basis, i.e., providing that a loss must be discovered within the bond period as a prerequisite to recovery of such loss, however, will not be required to have a discovery period if it contains a provision giving the insured the right to purchase a discovery period of one year in the event of termination or cancellation and the insured has already given the surety notice that it desires such discovery period.

(c) Other bond clauses. A bond shall not be adequate to meet the requirements of section 13, if, with respect to
bonding coverage required under section 13, it contains a clause, or is otherwise, in contravention of the law of the State in which it is executed.

§ 2580.412–20 Use of existing bonds, separate bonds and additional bonding.

(a) Additional bonding. Section 13 neither prevents additional bonding beyond that required by its terms, nor prescribes the form in which additional coverage may be taken. Thus, so long as a particular bond meets the requirements of the regulations in this part as to the persons required to be bonded and provides coverage for such persons in at least the minimum required amount, additional coverage as to persons or amount may be taken in any form, either on the same or separate bond.

(b) Use of existing bonds. Insofar as a bond currently in use is adequate to meet the requirements of the Act and the regulations in this part or may be made adequate to meet these requirements through rider, modification or separate agreement between the parties, no further bonding is required.

(c) Use of separate bonds. The choice of whether persons required to be bonded should be bonded separately or under the same bond, whether given plans should be used or separate bonds for Welfare and Pension Plans Disclosure Act bonding should be obtained, or whether the bond is underwritten by a single surety company or more than one surety company, either separately or on a cosurety basis, is left to the judgment of the parties concerned, so long as the bonding program adopted meets the requirements of the Act and the regulations in this part.

Subpart E—Qualified Agents, Brokers and Surety Companies for the Placing of Bonds

§ 2580.412–21 Corporate sureties holding grants of authority from the Secretary of the Treasury.

(a) The provisions of section 13 require that any surety company with which a bond is placed pursuant to that section must be a corporate surety which holds a grant of authority from the Secretary of the Treasury under the Act of July 30, 1947 (6 U.S.C. 6–13), as an acceptable surety on Federal bonds. The Act provides, among other things, that in order for a surety company to be eligible for such grant of authority, it must be incorporated under the laws of the United States or of any State and the Secretary of the Treasury shall be satisfied of certain facts relating to its authority and capitalization. Such grants of authority are evidenced by Certificates of Authority which are issued by the Secretary of the Treasury and which expire on the April 30 following the date of their issuance. A list of the companies holding such Certificates of Authority is published annually in the FEDERAL REGISTER, usually in May or June. Changes in the list, occurring between May 1 and April 30, either by addition to or removal from the list of companies, are also published in the FEDERAL REGISTER following each such change.

(b) Where a surety becomes insolvent and is placed in receivership, or if for any other reason the Secretary of the Treasury determines that its financial condition is not satisfactory to him and he revokes the authority of such company to act as an acceptable surety under the Act of July 30, 1947, the “administrator” of the insured plan shall, upon knowledge of such facts, be responsible for securing a new bond with an acceptable surety.

(c) In obtaining or renewing a bond, the plan administrator shall assure that the surety is one which satisfies the requirements of this section. If the bond is for a term of more than one year, the plan administrator, at the beginning of each reporting year, shall assure that the surety continues to satisfy the requirements of this subpart.

§ 2580.412–22 Interests held in agents, brokers and surety companies.

Section 13(c) prohibits the placing of bonds, required to be obtained pursuant to section 13, with any surety or other company, or through any agent or broker in whose business operations a plan or any party in interest in a
§ 2580.412–23 Exemption.

An exemption from the bonding requirements of subsection 13(a) of the Welfare and Pension Plans Disclosure Act is granted by this section whereby bonding arrangements (which otherwise comply with the requirements of section 13 of the Act and the exemptions issued thereunder) with companies authorized by the Secretary of the Treasury as acceptable reinsurers on Federal bonds will satisfy the bonding requirements of the Act.

§ 2580.412–24 Conditions of exemption.

(a) This exemption obtains only with respect to the requirements of section 13(a) of the Act that all bonds required thereunder shall have as surety thereon, a corporate surety company, which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury pursuant to the Act of July 30, 1947 (6 U.S.C. 6–13).

(b) The exemption is granted upon the condition that if for any reason the authority of any such company to act as an acceptable reinsuring company is terminated, the administrator of a plan insured with such company, shall, upon knowledge of such fact, be responsible for securing a new bond with a company acceptable under the Act and the exemptions issued thereunder.

(c) In obtaining or renewing a bond, the plan administrator shall ascertain that the surety is one which satisfies the requirements of the Act and the exemptions thereunder. If the bond is for a term of more than one year, the plan administrator, at the beginning of each reporting year, shall ascertain that the surety continues to do so.
of the Welfare and Pension Plans Disclosure Act is granted whereby banking institutions and trust companies specified in §2580.412–28 are not required to comply with subsections 13 (a) and (b) of the Act, with respect to welfare and pension benefit plans covered by the Act.

[34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

§ 2580.412–28 Conditions of exemption.

This exemption applies only to those banking institutions and trust companies subject to regulation and examination by the Comptroller of the Currency or the Board of Governors of the Federal Reserve System, or the Federal Deposit Insurance Corporation.

SAVINGS AND LOAN ASSOCIATIONS

SUBJECT TO FEDERAL REGULATION

§ 2580.412–29 Exemption.

An exemption from the bonding requirements of subsections 13 (a) and (b) of the Welfare and Pension Plans Disclosure Act is granted whereby savings and loan associations (including building and loan associations, cooperative banks and homestead associations) specified in §2580.412–30 are not required to comply with subsections 13 (a) and (b) of the Act, with respect to welfare and pension benefit plans covered by the Act for the benefit of persons other than employees of such savings and loan association is the administrator of such plans.


§ 2580.412–30 Conditions of exemption.

This exemption applies only to those savings and loan associations (including building and loan associations, cooperative banks and homestead associations) subject to regulation and examination by the Federal Home Loan Bank Board.


INSURANCE CARRIERS, SERVICE AND OTHER SIMILAR ORGANIZATIONS

§ 2580.412–31 Exemption.

An exemption from the bonding requirements of subsection 13 (a) and (b) of the Welfare and Pension Plans Disclosure Act is granted whereby any insurance carrier or service or other similar organization specified in §2580.412–32 is not required to comply with subsections 13 (a) and (b) of the Act with respect to any welfare or pension benefit plan covered by the Act which is established or maintained for the benefit of persons other than the employees of such insurance carrier or service or other similar organization.

[34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

§ 2580.412–32 Conditions of exemption.

This exemption applies only to those insurance carriers, service or other similar organizations providing or underwriting welfare or pension plan benefits in accordance with State law.

[34 FR 5158, Mar. 13, 1969. Redesignated at 50 FR 26706, June 28, 1985]

Subpart G—Prohibition Against Bonding by Parties Interested in the Plan


§ 2580.412–33 Introductory statement.

(a) This part discusses the meaning and scope of section 13(c) of the Welfare and Pension Plans Disclosure Act of 1958 (76 Stat. 39, 29 U.S.C. 308d(c)) (hereinafter referred to as the Act). This provision makes it unlawful “for any person to procure any bond [required by the Act] from any surety or other company or through any agent or broker in whose business operations such plan or any party in interest in such plan has any significant control or financial interest, direct or indirect.” Because the prohibition contained in this provision is broadly stated, it becomes a matter of importance to determine more specifically the types of arrangements intended to be prohibited.
(b) The provisions of section 13 of the Act, including 13(c) are subject to the general investigatory authority of the Director, Office of Labor-Management and Welfare-Pension Reports, embodied in section 9 of the Act. The correctness of an interpretation of these provisions can be determined finally and authoritatively only by the courts. It is necessary, however, for the Labor-Management Services Administrator to reach informed conclusions as to the meaning of the law to enable him to carry out his statutory duties of administration and enforcement. The interpretations of the Labor-Management Services Administrator contained in this part, which are issued upon the advice of the Solicitor of Labor, indicate the construction of the law which will guide the Labor-Management Services Administrator in performing his duties unless and until he is directed otherwise by authoritative ruling of the courts or unless and until he subsequently decides that his prior interpretation is incorrect. Under section 12 of the Act, the interpretations contained in this part, if relied upon in good faith, will constitute a defense in any action or proceeding based on any Act or omission in alleged violation of section 13(c) of the Act. The omission, however, to discuss a particular problem in this part, or in interpretations supplementing it, should not be taken to indicate the adoption of any position by the Labor-Management Services Administrator with respect to such problem or to constitute an administrative interpretation or practice. Interpretations of the Labor-Management Services Administrator with respect to 13(c) are set forth in this part to provide those affected by the provisions of the Act with "a practical guide * * * as to how the office representing the public interest in its enforcement will seek to apply it" (Skidmore v. Swift & Co., 323 U.S. 134, 138).

(c) To the extent that prior opinions and interpretations relating to 13(c) are inconsistent with the principles stated in this part, they are hereby rescinded and withdrawn.

§ 2580.412–35 Disqualification of agents, brokers and sureties.

Since 13(c) is to be construed as disqualifying any agent, broker, surety or other company from having a bond placed through or with it, if the plan or any party in interest in the plan has a significant financial interest or control in such agent, broker, surety or other company, a question of fact will necessarily arise in many cases as to whether the financial interest or control held is sufficiently significant to disqualify the agent, broker or surety. Although no rule of guidance can be established to govern each and every case in which this question arises, in general, the essential test is whether the existing financial interest or control held is incompatible with an unbiased exercise of judgment in regard to procuring the bond or bonding the plan’s personnel. In regard to the foregoing, it is also to be pointed out that lack of knowledge or consent on the part of persons responsible for procuring bonds with respect to the existence of a significant financial interest or control rendering the bonding arrangement unlawful will not be deemed a mitigating factor where such persons have failed to make a reasonable examination into the pertinent circumstances affecting the procuring of the bond.
§ 2580.412–36 Application of 13(c) to "party in interest".

(a) Under 13(c), an agent, broker or surety or other company is disqualified from having a bond placed through or with it if a "party in interest" in the plan has any significant control or financial interest in such agent, broker, surety or other company. Section 3(13) of the Act defines the term "party in interest" to mean "any administrator, officer, trustee, custodian, counsel, or employee of any employee welfare benefit plan or a person providing benefit plan services to any such plan, or an employer any of whose employees are covered by such a plan or officer or employee or agent of such employer, or an officer or agent or employee of an employee organization having members covered by such plan."

(b) A basic question presented is whether the effect of 13(c) is to prohibit persons from placing a bond through or with any "party in interest" in the plan. The language used in 13(c) appears to indicate that in this connection the intent of Congress was to eliminate those instances where the existing financial interest or control held by the "party in interest" in the agent, broker, surety or other company is incompatible with an unbiased exercise of judgment in regard to procuring the bond or bonding the plan's personnel. Accordingly, not all parties in interest are disqualified from procuring or providing bonds for the plan. Thus where a "party in interest" or its affiliate provides multiple benefit plan services to plans, persons are not prohibited from availing themselves of the bonding services provided by the "party in interest" or its affiliate merely because the plan has already availed itself, or will avail itself, of other services provided by the "party in interest." In this case, it is inherent in the nature of the "party in interest" or its affiliate as an individual or organization providing multiple benefit plan services, one of which is a bonding service, that the existing financial interest or control held is not, in and of itself, incompatible with an unbiased exercise of judgment in regard to procuring the bond or bonding the plan's personnel. In short, there is no distinction between this type of relationship and the ordinary arm's length business relationship which may be established between a plan-customer and an agent, broker or surety company, a relationship which Congress could not have intended to disturb. On the other hand, where a "party in interest" in the plan or an affiliate does not provide a bonding service as part of its general business operations, 13(c) would prohibit any person from procuring the bond through or with any agent, broker, surety or other company, with respect to which the "party in interest" has any significant control or financial interest, direct or indirect. In this case, the failure of the "party in interest" or its affiliate to provide a bonding service as part of its general business operations raises the possibility of less than an arm's length business relationship between the plan and the agent, broker, surety or other company since the objectivity of either the plan or the agent, broker or surety may be influenced by the "party in interest".

(c) The application of the principles discussed in this section is illustrated by the following examples:

Example 1. B, a broker, renders actuarial and consultant service to plan P. B has also procured a group life insurance policy for plan P. B may also place a bond for P with surety company S, provided that neither B nor P has any significant control or financial interest, direct or indirect, in S and provided that neither P nor any other "party in interest" as defined in section 3(13) of the Act, e.g., an officer of the plan, has any significant control or financial interest, direct or indirect, in B or S.

Example 2. I, a life insurance company, has provided a group life insurance policy for plan P. I is affiliated with S, a surety company, and has a significant financial interest or control in S. P is not prohibited from obtaining a bond from S since I's affiliation with S does not ordinarily, in and of itself, affect the objectivity of P in procuring the bond or the objectivity of S in bonding P's personnel. However, if any other "party in interest" as defined in section 3(13) of the Act, such as the employer whose employees are covered by P, should have a significant financial interest or control in S, S could not write the bond for P, since the employer's interest affects the objectivity of P and S.
§ 2582.8478–1 Temporary bonding requirements.

(a) General. Pending the issuance of permanent regulations under section 8478 of the Federal Employees’ Retirement System Act of 1986 (FERSA), any fiduciary with respect to the Thrift Savings Fund (Fund) established under FERSA or any person who handles funds or other property of the Fund, shall be deemed to be in compliance with the bonding requirements of section 8478 of FERSA if he or she is bonded in compliance with the temporary bonding regulations under section 412 of the Employee Retirement Income Security Act of 1974 (ERISA) set forth in part 2580 of title 29 of the Code of Federal Regulations.

(b) Application of ERISA temporary bonding rules. For purposes of this section:

1. Any reference to section 13 of the Welfare and Pension Plans Disclosure Act, as amended (WPPDA), or any section thereof in the ERISA temporary bonding regulations shall be deemed to refer to section 8478 of FERSA or the corresponding subsection thereof;

2. Where the particular phrases set forth in FERSA are not identical to the phrases in the WPPDA, ERISA or the ERISA temporary bonding regulations, the phrases appearing in FERSA shall be substituted by operation of law; and

3. Where the phrases are identical but the meaning is different, the meaning given such phrases by FERSA shall govern. For example, the phrase “every administrator, officer and employee of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handles funds or other property of such plan” which appears in the WPPDA and in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, “each fiduciary and each person who handles funds or property of the Thrift Savings Fund,” which is the term appearing in section 8478 of FERSA; the terms “employee benefit plan” and “plan” which appear in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, “Thrift Savings Fund,” which is the term appearing in section 8478 of FERSA; and the term “reporting year of the plan” which appears in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, “fiscal year of the Thrift Savings Fund.”

(c) Effectiveness. This section is effective until the earlier of the date of issuance by the Secretary of Labor of permanent regulations under section 8478 of FERSA or December 31, 1989.

[52 FR 35866, Sept. 23, 1987]

§ 2582.8478–2 Amount of the bond.

(a) General. Under the authority of section 8478(b)(1) of the Federal Employees’ Retirement System Act of 1986 (FERSA), the amount of a bond for each person, group or class to be bonded shall not be less than 10 percent of the amount of funds handled by such person, group or class with respect to any fiscal year of the Fund. In no case shall such bond be less than $1,000 nor more than $500,000. However, the Secretary of Labor reserves the authority under section 8478(b)(1) of FERSA to prescribe an amount in excess of
§ 2582.8478–3 Permanent bonding requirements.  

(a) General. Any fiduciary with respect to the Thrift Savings Fund (Fund) established under the Federal Employees’ Retirement System Act of 1986 (FERSA) or any person who handles funds or other property of the Fund shall be deemed to be in compliance with the bonding requirements of section 8478 of FERSA if he or she is bonded in compliance with the temporary bonding regulations under section 412 of the Employee Retirement Income Security Act of 1974 (ERISA) set forth in part 2580 of title 29 of the Code of Federal Regulations.  

(b) Application of ERISA temporary bonding rules. For purposes of this section:  

1. Any reference to section 13 of the Welfare and Pension Plans Disclosure Act, as amended (WPPDA), or any section thereof in the ERISA temporary bonding regulations shall be deemed to refer to section 8478 of FERSA or the corresponding subsection thereof;  

2. Where the particular phrases set forth in FERSA are not identical to the phrases in the WPPDA, ERISA or the ERISA temporary bonding regulations, the phrases appearing in FERSA shall be substituted by operation of law; and  

3. Where the phrases are identical but the meaning is different, the meaning given such phrases by FERSA shall govern. For example, the phrase “every administrator, officer and employee of any employee welfare benefit plan or of any employee pension benefit plan subject to this Act who handles funds or other property of such plan” which appears in the WPPDA and in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section “each fiduciary and each person who handles funds or other property of the Thrift Savings Fund,” which is the term appearing in section 8478 of FERSA; the terms “employee benefit plan” and “plan” which appear in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, “Thrift Savings Fund”; and the term “reporting year of the plan” which appears in the ERISA temporary bonding regulations shall be construed to mean, for purposes of this section, “fiscal year of the Thrift Savings Fund.”  

(c) Effective date. This section is effective January 1, 1990.  

§ 2582.8478–4 Permanent amount of the bond.  

(a) General. Under the authority of section 8478(b)(1) of the Federal Employees’ Retirement System Act of 1986 (FERSA), the amount of a bond for each person, group or class to be bonded shall not be less than 10 percent of the amount of funds handled by such person, group or class with respect to any fiscal year of the Fund. In no case shall such bond be less than $1,000 nor more than $500,000. However, the Secretary of Labor reserves the authority under section 8478(b)(1) of FERSA to prescribe an amount in excess of $500,000, after due notice and opportunity for hearing to all interested parties, and other consideration of the record.  

(b) Effective date. This section shall become effective January 1, 1990, and remain in effect until it is amended or withdrawn in accordance with section 8478(b)(1) of FERSA.
§ 2584.8477(e)–1 General.

5 U.S.C. 8477(e)(1)(E) provides that any fiduciary with respect to the Thrift Savings Fund of the Federal Employees Retirement System who allocates a fiduciary responsibility to another person pursuant to procedures prescribed by the Secretary of Labor shall not be liable for an act or omission of such person except in specified circumstances. This part sets forth the procedures which have been prescribed by the Secretary of Labor for the allocation of fiduciary responsibilities.

§ 2584.8477(e)–2 Allocation of fiduciary duties.

(a) The fiduciary duties of the Board as set forth at 5 U.S.C. 8472 may not be allocated to any person other than a member or members of the Board.

(b) The Executive Director may allocate authority and responsibility for the investment and management of the Fixed Income Investment Fund to a qualified professional asset manager(s).

(c) The Executive Director may allocate authority and responsibility for the investment and management of the Government Securities Investment Fund, the Common Stock Index Investment Fund and the Small Capitalization Stock Index Investment Fund to an investment manager(s).

(d) Notwithstanding any other provision of this part, no allocation may be made which would constitute:

(1) A violation of an express policy of the Board; or

(2) An invalid delegation according to the Act or any other law.

(e) Except as provided in this part, no person who has or may acquire fiduciary responsibility in connection with the Thrift Savings Fund may allocate such responsibility to another person.


§ 2584.8477(e)–3 Procedures for allocation.

(a) Any allocation made by the Board must—

(1) Be authorized by the concurring vote of a majority of the total membership of the Board;

(2) Be made in writing, signed by the Chairman of the Board and acknowledged in writing by the receiving Board member or members;

(3) Set forth the duties and responsibilities allocated, either in the body of the document or by reference to another document existing at the time of the allocation; and

(4) Be communicated in an appropriate written form to the Executive Director, the participants and the beneficiaries of the Thrift Savings Fund.

(b) Any allocation made by the Executive Director must—

(1) Be made in writing, signed by the Executive Director and acknowledged in writing by the receiving fiduciary;

(2) Set forth the duties and responsibilities allocated, either in the body of the document or by reference to another document existing at the time of the allocation; and

(3) Be communicated in an appropriate written form to the participants and beneficiaries of the Thrift Savings Fund.

§ 2584.8477(e)–4 Revocation and termination of allocation.

(a) Any allocation made pursuant to this part must be revocable at will by the allocating fiduciary, subject only to notice which is reasonable under the circumstances.

(b) Any revocation by the allocating fiduciary or termination of an allocation by the fiduciary to whom duties have been allocated must set forth in writing the duties and responsibilities as to which the revocation or termination is effective, either in the body of the document or by reference to another document existing at the time of the revocation or termination.
(c) Any revocation of an allocation must—
   (1) In the case of an allocation which was made by the Board, be authorized by the concurring vote of a majority of the total membership of the Board and be signed by the Chairman of the Board, or
   (2) In the case of an allocation which was made by the Executive Director, be signed by the Executive Director.
   (d) Any termination of an allocation, to be effective, must—
      (1) In the case of an allocation which was made by the Board, be signed by the terminating fiduciary and acknowledged in writing by the Chairman of the Board, or
      (2) In the case of an allocation which was made by the Executive Director, be signed by the terminating fiduciary and acknowledged in writing by the Executive Director.
   (e) Any revocation or termination of an allocation must be communicated by the Executive Director in an appropriate written form to the participants and beneficiaries of the Thrift Savings Fund in a manner which identifies the person(s) assuming the responsibilities which were the subject of the revocation or termination.

§ 2584.8477(e)–5 Effect of allocation.

Where fiduciary responsibility has been allocated to another person or persons pursuant to the procedures contained in this part, the allocating fiduciary shall not be liable for any act or omission of such person or persons unless:

(a) The allocating fiduciary has violated 5 U.S.C. 8477(b) with respect to—
   (1) The allocation or the continuation of the allocation,
   (2) The implementation of these procedures,
   (3) The duty to monitor the performance of such person or persons in a reasonable manner during the life of the allocation, or
   (b) The allocating fiduciary would otherwise be liable in accordance with 5 U.S.C. 8477(e)(1)(D).

§ 2584.8477(e)–6 Definitions.

As used in this part:

(b) Board means the Federal Retirement Thrift Investment Board established pursuant to 5 U.S.C. 8472;
(c) Common Stock Index Investment Fund means the fund established under 5 U.S.C. 8438(b)(1)(C);
(d) Executive Director means the executive director of the Federal Retirement Thrift Investment Board as appointed pursuant to 5 U.S.C. 8474;
(e) Fiduciary duty and fiduciary responsibility mean any duty or responsibility which involves the exercise of discretionary authority or discretionary control over—
   (1) The management or disposition of the assets of the Thrift Savings Fund, or
   (2) The administration of the Thrift Savings Fund;
(f) Fixed Income Investment Fund means the fund established under 5 U.S.C. 8438(b)(1)(B);
(g) Government Securities Investment Fund means the fund established under 5 U.S.C. 8438(b)(1)(A);
(h) International Stock Index Investment Fund means the fund established under 5 U.S.C. 8438(b)(1)(E);
(i) Investment manager means any fiduciary who—
   (1) Has the power to manage, acquire or dispose of any asset of the plan,
   (2) Is:
      (i) Registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. 80b–1),
      (ii) Not registered as an investment adviser under such Act by reason of paragraph (1) of section 203A(a) of such Act (15 U.S.C. 80b–3a) but is registered as an investment adviser under the laws of the state (referred to in such paragraph (1)) in which it maintains its principal office and place of business, and, at the time the fiduciary last filed the registration form most recently filed by the fiduciary with the Secretary of Labor, also filed a copy of such form with the Secretary of Labor,
      (iii) A bank, as defined in that Act, or
§ 2584.8477(e)–7

(iv) An insurance company qualified to perform services described in paragraph (i)(1) of this section under the laws of more than one state, and

(3) Has acknowledged in writing that he or she is a fiduciary with respect to the Thrift Savings Fund;

(j) Qualified professional asset manager has the meaning which is prescribed at 5 U.S.C. 8438(a)(7);

(k) Small Capitalization Stock Index Investment Fund means the fund established under 5 U.S.C. 8438(b)(1)(D);

(l) Thrift Savings Fund means the fund established under 5 U.S.C. 8437.


§ 2584.8477(e)–7 Effective date.

This section is effective December 29, 1988, and liability for any transaction which occurs on or after this date will be governed by this section only. In accordance with section 114(a) of Pub. L. 99–556, the interim regulations promulgated by the Board appearing at title 5, CFR, chapter VI, §§1660.1 through 1660.5 will no longer be effective as of December 29, 1988. Liability for transactions which occur before the effective date of this regulation, however, will continue to be governed by allocations made both during the statutorily defined effective period of the previously cited interim regulations and pursuant to the requirements of those regulations.
§ 2589.1 Civil penalties under section 8477(e)(1)(B) of FERSA.

(a) Section 8477(e)(1)(B) of FERSA, 5 U.S.C. 8477(e)(1)(B), permits the Secretary of Labor to assess a civil penalty against a party in interest who engages in a prohibited transaction with respect to the Thrift Savings Fund. The initial penalty under section 8477(e)(1)(B) is five percent of the “amount involved” in each such transaction for each year or part thereof during which the prohibited transaction continues. However, if the prohibited transaction is not corrected during the “correction period,” the civil penalty may be in an amount not more than 100% of the “amount involved.” The Department of Labor will apply the definitions set out in §2560.502i–1(b) through (e) of this chapter of title 29 (civil penalties under section 502(i) of ERISA) in determining the “amount involved,” “correction,” “correction period,” and for computation of the section 8477(e)(1)(B) penalty.

(b) The rules of practice set forth in §§2570.1–2570.12 of part 2570, subpart A of subchapter G of this chapter of title 29 (procedures for the assessment of civil sanctions under ERISA section 502(i)) are applicable to prohibited transaction penalty proceedings under FERSA section 8477(e)(1)(B).
§ 2590.606–1 General notice of continuation coverage.

(a) General. Pursuant to section 606(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of part 6 of title I of the Act shall provide, in accordance with this section, written notice to each covered employee and spouse of the covered employee (if any) of the right to continuation coverage provided under the plan.

(b) Timing of notice. (1) The notice required by paragraph (a) of this section shall be furnished to each employee

810
and each employee’s spouse, not later than the earlier of:

(i) The date that is 90 days after the date on which such individual’s coverage under the plan commences, or, if later, the date that is 90 days after the date on which the plan first becomes subject to the continuation coverage requirements; or

(ii) The first date on which the administrator is required, pursuant to §2590.606–4(b), to furnish the covered employee, spouse, or dependent child of such employee notice of a qualified beneficiary’s right to elect continuation coverage.

(2) A notice that is furnished in accordance with paragraph (b)(1) of this section shall, for purposes of section 606(a)(1) of the Act, be deemed to be provided at the time of commencement of coverage under the plan.

(3) In any case in which an administrator is required to furnish a notice to a covered employee or spouse pursuant to paragraph (b)(1)(ii) of this section, the furnishing of a notice to such individual in accordance with §2590.606–4(b) shall be deemed to satisfy the requirements of this section.

(c) Content of notice. The notice required by paragraph (a) of this section shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(1) The name of the plan under which continuation coverage is available, and the name, address and telephone number of a party or parties from whom additional information about the plan and continuation coverage can be obtained;

(2) A general description of the continuation coverage under the plan, including identification of the classes of individuals who may become qualified beneficiaries, the types of qualifying events that may give rise to the right to continuation coverage, the obligation of the employer to notify the plan administrator of the occurrence of certain qualifying events, the maximum period for which continuation coverage may be available, when and under what circumstances continuation coverage may be extended beyond the applicable maximum period, and the plan’s requirements applicable to the payment of premiums for continuation coverage;

(3) An explanation of the plan’s requirements regarding the responsibility of a qualified beneficiary to notify the administrator of a qualifying event that is a divorce, legal separation, or a child’s ceasing to be a dependent under the terms of the plan, and a description of the plan’s procedures for providing such notice;

(4) An explanation of the plan’s requirements regarding the responsibility of qualified beneficiaries who are receiving continuation coverage to provide notice to the administrator of a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.), that a qualified beneficiary is disabled, and a description of the plan’s procedures for providing such notice;

(5) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(6) A statement that the notice does not fully describe continuation coverage or other rights under the plan and that more complete information regarding such rights is available from the plan administrator and in the plan’s SPD.

(d) Single notice rule. A plan administrator may satisfy the requirement to provide notice in accordance with this section to a covered employee and the covered employee’s spouse by furnishing a single notice addressed to both the covered employee and the covered employee’s spouse, if, on the basis of the most recent information available to the plan, the covered employee’s spouse resides at the same location as the covered employee, and the spouse’s coverage under the plan commences on or after the date on which the covered employee’s coverage commences, but not later than the date on which the notice required by this section is required to be provided to the covered employee. Nothing in this section shall be construed to create a requirement to provide a separate notice to dependent children who share a residence with a covered employee or a
covered employee’s spouse to whom notice is provided in accordance with this section.

(e) Notice in summary plan description. A plan administrator may satisfy the requirement to provide notice in accordance with this section by including the information described in paragraphs (c)(1), (2), (3), (4), and (5) of this section in a summary plan description meeting the requirements of §2520.102–3 of this chapter furnished in accordance with paragraph (b) of this section.

(f) Delivery of notice. The notice required by this section shall be furnished in a manner consistent with the requirements of §2520.104b–1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(g) Model notice. The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of this section. Use of the model notice is not mandatory. The model notice reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language, and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (c) of this section.

(h) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.
APPENDIX TO § 2590.606-1

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

**CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [add if Plan provides retiree health coverage: commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice].

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)
§ 2590.606–2 Notice requirement for employers.

(a) General. Pursuant to section 606(a)(2) of the Employee Retirement Income Security Act of 1974, as amended (the Act), except as otherwise provided herein, the employer of a covered employee under a group health plan subject to the continuation coverage requirements of part 6 of title I of the Act shall provide, in accordance with this section, notice to the administrator of the plan of the occurrence of a qualifying event that is the covered employee’s death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement, or a proceeding in a case under title 11, United States Code, with respect to the employer from whose employment the covered employee retired at any time.

(b) Timing of notice. The notice required by this section shall be furnished to the administrator of the plan of the occurrence of a qualifying event that is the covered employee’s death, termination of employment (other than by reason of gross misconduct), reduction in hours of employment, Medicare entitlement, or a proceeding in a case under title 11, United States Code, with respect to the employer from whose employment the covered employee retired at any time.

(c) Content of notice. The notice required by this section shall include sufficient information to enable the administrator to determine the plan, the covered employee, the qualifying event, and the date of the qualifying event.

(d) Multiemployer plan special rules. This section shall not apply to any employer that maintains a multiemployer plan, with respect to qualifying events affecting coverage under such plan, if the plan provides, pursuant to section 606(b) of the Act, that the administrator shall determine whether such a qualifying event has occurred.

(e) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

§ 2590.606–3 Notice requirements for covered employees and qualified beneficiaries.

(a) General. In accordance with the authority of sections 505 and 606(a)(3) of the Employee Retirement Income Security Act of 1974, as amended (the Act), this section sets forth requirements for group health plans subject to the continuation coverage requirements of part 6 of title I of the Act with respect to the responsibility of
covered employees and qualified beneficiaries to provide the following notices to administrators:

1. Notice of the occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse;

2. Notice of the occurrence of a qualifying event that is a beneficiary’s ceasing to be covered under a plan as a dependent child of a participant;

3. Notice of the occurrence of a second qualifying event after a qualified beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months;

4. Notice that a qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), to be disabled at any time during the first 60 days of continuation coverage; and

5. Notice that a qualified beneficiary, with respect to whom a notice described in paragraph (a)(4) of this section has been provided, has subsequently been determined by the Social Security Administration, under title II or XVI of the SSA to no longer be disabled.

(b) Reasonable procedures. (1) A plan subject to the continuation coverage requirements shall establish reasonable procedures for the furnishing of the notices described in paragraph (a) of this section.

(2) For purposes of this section, a plan’s notice procedures shall be deemed reasonable only if such procedures:

(i) Are described in the plan’s summary plan description required by §2520.102–3 of this chapter;

(ii) Specify the individual or entity designated to receive such notices;

(iii) Specify the means by which notice may be given;

(iv) Describe the information concerning the qualifying event or determination of disability that the plan deems necessary in order to provide continuation coverage rights consistent with the requirements of the Act; and

(v) Comply with the requirements of paragraphs (c), (d), and (e) of this section.

(3) A plan’s procedures will not fail to be reasonable, pursuant to this section, solely because the procedures require a covered employee or qualified beneficiary to utilize a specific form to provide notice to the administrator, provided that any such form is easily available, without cost, to covered employees and qualified beneficiaries.

(4) If a plan has not established reasonable procedures for providing a notice required by this section, such notice shall be deemed to have been provided when a written or oral communication identifying a specific event is made in a manner reasonably calculated to bring the information to the attention of any of the following:

(i) In the case of a single-employer plan, the person or organizational unit that customarily handles employee benefits matters of the employer;

(ii) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee, or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily are referred; or

(iii) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization subject to regulation under the insurance laws of one or more States, the person or organizational unit that customarily handles claims for benefits under the plan or any officer of the insurance company, insurance service, or other similar organization.

(c) Periods of time for providing notice. A plan may establish a reasonable period of time for furnishing any of the notices described in paragraph (a) of this section, provided that any time limit imposed by the plan with respect to a particular notice may not be shorter than the time limit described in this paragraph (c) with respect to that notice.
§ 2590.606–3 29 CFR Ch. XXV (7–1–15 Edition)

(1) Time limits for notices of qualifying events. The period of time for furnishing a notice described in paragraph (a)(1), (2), or (3) of this section may not end before the date that is 60 days after the latest of: (i) The date on which the relevant qualifying event occurs; (ii) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (iii) The date on which the qualified beneficiary is informed, through the furnishing of the plan’s summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan’s procedures for providing such notice to the administrator.

(2) Time limits for notice of disability determination. (i) Subject to paragraph (c)(2)(ii) of this section, the period of time for furnishing the notice described in paragraph (a)(4) of this section may not end before the date that is 60 days after the latest of: (A) The date of the disability determination by the Social Security Administration; (B) The date on which a qualifying event occurs; (C) The date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (D) The date on which the qualified beneficiary is informed, through the furnishing of the plan’s summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan’s procedures for providing such notice to the administrator.

(ii) Notwithstanding paragraph (c)(2)(i) of this section, a plan may require the notice described in paragraph (a)(4) of this section to be furnished before the end of the first 18 months of continuation coverage.

(3) Time limits for notice of change in disability status. The period of time for furnishing the notice described in paragraph (a)(5) of this section may not end before the date that is 30 days after the later of: (i) The date of the final determination by the Social Security Administration, under title II or XVI of the SSA, that the qualified beneficiary is no longer disabled; or (ii) The date on which the qualified beneficiary is informed, through the furnishing of the plan’s summary plan description or the notice described in § 2590.606–1, of both the responsibility to provide the notice and the plan’s procedures for providing such notice to the administrator.

(d) Required contents of notice. (1) A plan may establish reasonable requirements for the content of any notice described in this section, provided that a plan may not deem a notice to have been provided untimely if such notice, although not containing all of the information required by the plan, is provided within the time limit established under the plan in conformity with paragraph (c) of this section, and the administrator is able to determine from such notice the plan, the covered employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event (if any) occurred.

(2) An administrator may require a notice that does not contain all of the information required by the plan to be supplemented with the additional information necessary to meet the plan’s reasonable content requirements for such notice in order for the notice to be deemed to have been provided in accordance with this section.

(e) Who may provide notice. With respect to each of the notice requirements of this section, any individual who is either the covered employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

(f) Plan provisions. To the extent that a plan provides a covered employee or qualified beneficiary a period of time longer than that specified in this section to provide notice to the administrator, the terms of the plan shall govern the time frame for such notice.

(g) Additional rights to continuation coverage. Nothing in this section shall
be construed to preclude a plan from providing, in accordance with its terms, continuation coverage to a qualified beneficiary although a notice requirement of this section was not satisfied.

(b) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.

§ 2590.606–4 Notice requirements for plan administrators.

(a) General. Pursuant to section 606(a)(4) of the Employee Retirement Income Security Act of 1974, as amended (the Act), the administrator of a group health plan subject to the continuation coverage requirements of Part 6 of title I of the Act shall provide, in accordance with this section, notice to each qualified beneficiary of the qualified beneficiary’s rights to continuation coverage under the plan.

(b) Notice of right to elect continuation coverage. (1) Except as provided in paragraph (b)(2) or (3) of this section, upon receipt of a notice of qualifying event furnished in accordance with § 2590.606–2 or § 2590.606–3, the administrator shall furnish to each qualified beneficiary, not later than 14 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

(2) In the case of a plan with respect to which an employer of a covered employee is also the administrator of the plan, except as provided in paragraph (b)(3) of this section, if the employer is otherwise required to furnish a notice of qualifying event to an administrator pursuant to § 2590.606–2, the administrator shall furnish to each qualified beneficiary, not later than 44 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

(3) In the case of a plan that is a multiemployer plan, a notice meeting the requirements of paragraph (b)(4) of this section shall be furnished not later than the later of:

(i) The end of the time period provided in paragraph (b)(1) of this section; or

(ii) The end of the time period provided in the terms of the plan for such purpose.

(4) The notice required by this paragraph (b) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The name of the plan under which continuation coverage is available; and the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits;

(ii) Identification of the qualifying event;

(iii) Identification, by status or name, of the qualified beneficiaries who are recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event, and the date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected;

(iv) A statement that each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage, that a covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of a minor child;

(v) An explanation of the plan’s procedures for electing continuation coverage, including an explanation of the time period during which the election must be made, and the date by which the election must be made;

(vi) An explanation of the consequences of failing to elect or waiving...
continuation coverage, including an explanation that a qualified beneficiary’s decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under part 7 of title I of the Act, with a reference to where a qualified beneficiary may obtain additional information about such rights; and a description of the plan’s procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made;

(vii) A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either by providing a description of the coverage or by reference to the plan’s summary plan description;

(viii) An explanation of the maximum period for which continuation coverage will be available under the plan, if elected; an explanation of the continuation coverage termination date; and an explanation of any events that might cause continuation coverage to be terminated earlier than the end of the maximum period;

(ix) A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), that the qualified beneficiary is disabled, and the length of any such extension;

(x) In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months, a description of the plan’s requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event and notice of a disability determination under the SSA, along with a description of the plan’s procedures for providing such notices, including the times within which such notices must be provided and the consequences of failing to provide such notices. The notice shall also explain the responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled;

(xi) A description of the amount, if any, that each qualified beneficiary will be required to pay for continuation coverage;

(xii) A description of the due dates for payments, the qualified beneficiaries’ right to pay on a monthly basis, the grace periods for payment, the address to which payments should be sent, and the consequences of delayed payment and non-payment;

(xiii) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(xiv) A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information regarding such rights is available in the plan’s summary plan description or from the plan administrator.

(c) Notice of unavailability of continuation coverage. (1) In the event that an administrator receives a notice furnished in accordance with §2590.606-3 relating to a qualifying event, second qualifying event, or determination of disability by the Social Security Administration regarding a covered employee, qualified beneficiary, or other individual and determines that the individual is not entitled to continuation coverage under part 6 of title I of the Act, the administrator shall provide to such individual an explanation as to why the individual is not entitled to continuation coverage.

(2) The notice required by this paragraph (c) shall be written in a manner calculated to be understood by the average plan participant and shall be furnished by the administrator in accordance with the time frame set out in paragraph (b) of this section that would apply if the administrator received a notice of qualifying event and determined that the individual was entitled to continuation coverage.

(d) Notice of termination of continuation coverage. (1) The administrator of a plan that is providing continuation coverage, including an explanation that a qualified beneficiary’s decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under part 7 of title I of the Act, with a reference to where a qualified beneficiary may obtain additional information about such rights; and a description of the plan’s procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made;

(vii) A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either by providing a description of the coverage or by reference to the plan’s summary plan description;

(viii) An explanation of the maximum period for which continuation coverage will be available under the plan, if elected; an explanation of the continuation coverage termination date; and an explanation of any events that might cause continuation coverage to be terminated earlier than the end of the maximum period;

(ix) A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), that the qualified beneficiary is disabled, and the length of any such extension;

(x) In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months, a description of the plan’s requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event and notice of a disability determination under the SSA, along with a description of the plan’s procedures for providing such notices, including the times within which such notices must be provided and the consequences of failing to provide such notices. The notice shall also explain the responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled;
coverage to one or more qualified beneficiaries with respect to a qualifying event shall provide, in accordance with this paragraph (d), notice to each such qualified beneficiary of any termination of continuation coverage that takes effect earlier than the end of the maximum period of continuation coverage applicable to such qualifying event.

(2) The notice required by this paragraph (d) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The reason that continuation coverage has terminated earlier than the end of the maximum period of continuation coverage applicable to such qualifying event;

(ii) The date of termination of continuation coverage; and

(iii) Any rights the qualified beneficiary may have under the plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right.

(3) The notice required by this paragraph (d) shall be furnished by the administrator as soon as practicable following the administrator’s determination that continuation coverage shall terminate.

(e) Special notice rules. The notices required by paragraphs (b), (c), and (d) of this section shall be furnished to each qualified beneficiary or individual, except that:

(1) An administrator may provide notice to a covered employee and the covered employee’s spouse by furnishing a single notice addressed to both the covered employee and the covered employee’s spouse, if, on the basis of the most recent information available to the plan, the covered employee’s spouse resides at the same location as the covered employee; and

(2) An administrator may provide notice to each qualified beneficiary who is the dependent child of a covered employee by furnishing a single notice to the covered employee or the covered employee’s spouse, if, on the basis of the most recent information available to the plan, the dependent child resides at the same location as the individual to whom such notice is provided.

(f) Delivery of notice. The notices required by this section shall be furnished in any manner consistent with the requirements of §2520.104b–1 of this chapter, including paragraph (c) of that section relating to the use of electronic media.

(g) Model notice. The appendix to this section contains a model notice that is intended to assist administrators in discharging the notice obligations of paragraph (b) of this section. Use of the model notice is not mandatory. The model notice reflects the requirements of this section as they would apply to single-employer group health plans and must be modified if used to provide notice with respect to other types of group health plans, such as multiemployer plans or plans established and maintained by employee organizations for their members. In order to use the model notice, administrators must appropriately add relevant information where indicated in the model notice, select among alternative language and supplement the model notice to reflect applicable plan provisions. Items of information that are not applicable to a particular plan may be deleted. Use of the model notice, appropriately modified and supplemented, will be deemed to satisfy the notice content requirements of paragraph (b)(4) of this section.

(h) Applicability. This section shall apply to any notice obligation described in this section that arises on or after the first day of the first plan year beginning on or after November 26, 2004.
APPENDIX TO § 2590.606-4

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE
(For use by single-employer group health plans)

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on [enter date] due to [check appropriate box]:

☐ End of employment ☐ Reduction in hours of employment
☐ Death of employee ☐ Divorce or legal separation
☐ Entitlement to Medicare ☐ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to ___ months [enter 18 or 36, as appropriate and check appropriate box or boxes; names may be added]:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on [enter date] and can last until [enter date]. [Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].]

COBRA continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.] You do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].
COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: [Enter Name and Address]

This Election Form must be completed and returned by mail [or describe other means of submission and due date]. If mailed, it must be post-marked no later than [enter date].

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the [enter name of plan] (the Plan) as indicated below:

Name  Date of Birth  Relationship to Employee  SSN (or other identifier)

a.  

[Add if appropriate: Coverage option elected: ________________]

b.  

[Add if appropriate: Coverage option elected: ________________]

c.  

[Add if appropriate: Coverage option elected: ________________]

____________________________  _______________________
Signature  Date

____________________________  _______________________
Print Name  Relationship to individual(s) listed above

____________________________  _______________________
____________________________  _______________________
____________________________  _______________________
Print Address  Telephone number
§ 2590.606-4

29 CFR Ch. XXV (7-1-15 Edition)

IMPORTANT INFORMATION
ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including [add if applicable: open enrollment and] special enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

[If the maximum period shown on page 1 of this notice is less than 36 months, add the following three paragraphs:]
How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify [enter name of party responsible for COBRA administration] of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA’s determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee’s spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

825
In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**How much does COBRA continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

*If employees might be eligible for trade adjustment assistance, the following information may be added:* The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-626-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

**When and how must payment for COBRA continuation coverage be made?**

**First payment for continuation coverage**

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact
[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan] to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the [enter due day for each monthly payment] for that coverage period. [If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates: ]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [select one: will or will not] send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period [or enter longer period permitted by Plan] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. [If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.]

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[enter appropriate payment address]

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].
§ 2590.609–1 29 CFR Ch. XXV (7–1–15 Edition)

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes

In order to protect your and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

{69 FR 30997, May 26, 2004; 69 FR 34921, June 23, 2004}

§ 2590.609–1 [Reserved]

§ 2590.609–2 National Medical Support Notice.

(a) This section promulgates the National Medical Support Notice (the Notice), as mandated by section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105–200). If the Notice is appropriately completed and satisfies paragraphs (3) and (4) of section 609(a) of the Employee Retirement Income Security Act (ERISA), the Notice is deemed to be a qualified medical child support order (QMCSO) pursuant to ERISA section 609(a)(5)(C). Section 609(a) of ERISA delineates the rights and obligations of the alternate recipient (child), the participant, and the group health plan under a QMCSO. A copy of the Notice is available on the Internet at http://www.dol.gov/ebsa.

(b) For purposes of this section, a plan administrator shall find that a Notice is appropriately completed if it contains the name of an Issuing Agency, the name and mailing address (if any) of an employee who is a participant under the plan, the name and mailing address of one or more alternate recipient(s) (child(ren) of the participant) (or the name and address of a substituted official or agency which has been substituted for the mailing address of the alternate recipient(s)), and identifies an underlying child support order.

(c)(1) Under section 609(a)(3)(A) of ERISA, in order to be qualified, a medical child support order must clearly specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient. Section 609(a)(3)(B) of ERISA requires a reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined. Section 609(a)(3)(C) of ERISA requires that the order specify the period to which such order applies.

(2) The Notice satisfies ERISA section 609(a)(3)(A) by including the necessary identifying information described in § 2590.609–2(b).

(3) The Notice satisfies ERISA section 609(a)(3)(B) by having the Issuing Agency identify either the specific type of coverage or all available group health coverage. If an employer receives a Notice that does not designate either specific type(s) of coverage or all available coverage, the employer and plan administrator should assume that all are designated. The Notice further satisfies ERISA section 609(a)(3)(B) by instructing the plan administrator that if a group health plan has multiple options and the participant is not enrolled, the Issuing Agency will make a selection after the Notice is qualified, and, if the Issuing Agency does not respond within 20 days, the child will be enrolled under the plan’s default option (if any).

(4) Section 609(a)(3)(C) of ERISA is satisfied because the Notice specifies that the period of coverage may only
end for the alternate recipient(s) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.

(d)(1) Under ERISA section 609(a)(4), a qualified medical child support order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act, 42 U.S.C. 1396g–1.

(2) The Notice satisfies the conditions of ERISA section 609(a)(4) because it requires the plan to provide to an alternate recipient only those benefits that the plan provides to any dependent of a participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of a State law described in such section 1908.

(e) For the purposes of this section, an ‘Issuing Agency’ is a State agency that administers the child support enforcement program under Part D of Title IV of the Social Security Act.

§2590.701–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§2590.701 through 2590.734.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) COBRA continuation coverage means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) COBRA continuation provision means sections 601–608 of the Act, section 4980B of the Internal Revenue Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), 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 §2590.701–4(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.

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 means the first day of coverage 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.

Excepted benefits means the benefits described as excepted in §2590.732(c).

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.

Genetic information has the meaning given in the term in §2590.702–1(a)(3) of this Part.

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 §2590.732(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.

Health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Act). Such term does not include a group health plan.

Health maintenance organization or HMO means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the 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
Employee Benefits Security Admin., Labor § 2590.701–2

State elects otherwise in accordance with section 279(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.

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a health insurance issuer.

Late enrollee means an individual whose enrollment in a plan is a late enrollment.

Late enrollment means enrollment of an individual under a group health plan other than on the earliest date on which coverage can become effective for the individual under the terms of the plan; or through special enrollment. (For rules relating to special enrollment, see § 2590.701–6.) If an individual ceases to be eligible for coverage under a 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.

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means participant within the meaning of section 3(7) of the Act.

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
§ 2590.701–3

medical records relating to the pre-enrollment period.

Public health plan means public health plan within the meaning of §2590.701–4(a)(1)(ix).

Public Health Service Act (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 §2590.701–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in §2590.701–6.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a State health benefits risk pool within the meaning of §2590.701–4(a)(1)(vii).

Waiting period means waiting period within the meaning of §2590.715–2708(b).

(a) Preexisting condition exclusion defined—(1) A preexisting condition exclusion means a preexisting condition exclusion within the meaning set forth in §2590.701–2 of this part.

(2) 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.

(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. The exclusion of benefits, therefore, is prohibited.

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 prohibited.

Example 3. (i) Facts. A group health plan provides coverage for the treatment of diabetes, generally not subject to any requirement to obtain an approval for a treatment plan. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a requirement to obtain approval of a treatment plan in advance.

(ii) Conclusion. In this Example 3, the requirement to obtain advance approval of a treatment plan 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 prohibited.

Example 4. (i) Facts. A group health plan provides coverage for three infertility treatments. The plan counts against the three-treatment limit 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 treatment limit for that condition 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. The plan provision, therefore, is prohibited.

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. The plan provision, therefore, is prohibited.

Example 6. (i) Facts. A group health plan provides coverage for medically necessary items and services, generally including
§ 2590.701-4 Rules relating to creditable coverage.

(a) General rules—(1) Creditable coverage. For purposes of this section, except as provided in paragraph (a)(2) of this section, the term creditable coverage means coverage of an individual under any of the following:

(ii) Health insurance coverage as defined in §2590.701-2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, uniformed services means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(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 §2590.732).

(b) Counting creditable coverage rules superseded by prohibition on preexisting condition exclusion. See §2590.715–2704 for rules prohibiting the imposition of a preexisting condition exclusion.

§2590.701–5 Evidence of creditable coverage.

(a) In general. The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. See §2590.715–2704 for rules prohibiting the imposition of a preexisting condition exclusion.

(b) Applicability. The provisions of this section apply beginning December 31, 2014.

§2590.701–6 Special enrollment periods.

(a) Special enrollment for certain individuals who lose coverage—(1) In general. A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in §2590.701–2) 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.

(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)(2)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(2)(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)(2)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(2)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(i), 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’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.
Employee Benefits Security Admin., Labor § 2590.701-6

(1) 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)(i) 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; and

(D) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in §2590.702(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 §2590.701–2.)

(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.
(A) Applying for special enrollment and effective date of coverage—(1) 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 to request enrollment (for the employee or the employee's dependent).

(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, and a health insurance issuer offering health insurance coverage in connection with 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.

(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)(ii) 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 §2590.710-2) 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 or issuer 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 issuer 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. D requests enrollment for E on January 1. The plan must enroll E in the HMO 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.

(3) The rules of this section are illustrated by the following example:

Example. (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).

§ 2590.701–7 HMO affiliation period as an alternative to a preexisting condition exclusion.

The rules for HMO affiliation periods have been superseded by the prohibition on preexisting condition exclusions. See § 2590.715–2704 for rules prohibiting the imposition of a preexisting condition exclusion.


§ 2590.701–8 Interaction With the Family and Medical Leave Act. [Reserved]

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) Health factors. (1) The term health factor means, in relation to an individual, any of the following health status-related factors:

(i) Health status;

(ii) Medical condition (including both physical and mental illnesses), as defined in § 2590.701–2;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information, as defined in § 2590.702–1(a)(3) of this Part;

(vii) Evidence of insurability;
or

(viii) Disability.

(2) Evidence of insurability includes—

(i) Conditions arising out of acts of domestic violence; and

(ii) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

(3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under § 2590.701–6, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.)

(b) Prohibited discrimination in rules for eligibility—(1) In general—(i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of paragraph (b)(2) of this section (explaining how this rule applies to benefits), paragraph (d) of this section (containing rules for establishing groups of similarly situated individuals), paragraph (e) of this section (relating to non-confinement, 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);
§ 2590.702

(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).

Example 3. (i) Facts. Under an employer’s group health plan, all employees generally may enroll within the first 30 days of employment. However, individuals who participate in certain recreational activities, including motorcycling, are excluded from coverage.

(ii) Conclusion. In this Example 3, excluding from the plan individuals who participate in recreational activities, such as motorcycling, is a rule for eligibility that discriminates based on one more health factors and thus violates this paragraph (b)(1).

Example 4. (i) Facts. A group health plan applies for a group health policy offered by an issue. As part of the application, the insurer 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 insurer excludes A and A’s dependents from the group policy it offers to the employer.

(ii) Conclusion. In this Example 4, the insurer’s exclusion of A and A’s dependents from coverage is a rule for eligibility that discriminates based on one or more health factors, and thus violates this paragraph (b)(1). (If the employer is a small employer under 45 CFR 144.103 (generally, an employer with 50 or fewer employees), the insurer 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 issue basis to all small employers and to accept every eligible individual in every small employer group.) If the plan provides coverage through this policy and does not provide equivalent coverage for A and A’s dependents through other means, the plan will also violate this paragraph (b)(1).

(2) Application to benefits—(i) General rule—(A) Under this section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

(B) However, benefits provided under a plan 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 or issuer 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 Affordable Care Act (including the requirements related to essential health benefits), 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 $10,000 annual limit on a specific covered benefit that is not an essential health benefit 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 coverage of the specific, non-essential health benefit up to $10,000 is 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 $500 deductible on all benefits 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 $2,000 deductible 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 overwhelming evidence to the contrary, the plan violates this paragraph (b)(2)(i).

Example 3. (i) Facts. A group health plan applies for a group health policy offered by an issuer. Individual C is covered under the plan and has an adverse health condition. As part of the application, the issuer receives health information about the individuals to be covered, including information about C's adverse health condition. The policy form offered by the issuer generally provides benefits for the adverse health condition that C has, but in this case the issuer offers the plan a policy modified by a rider that excludes benefits for C for that condition. The exclusionary rider is made effective the first day of the next plan year.

(ii) Conclusion. In this Example 3, the issuer violates this paragraph (b)(2)(i) because benefits for C's condition are available to other individuals in the group of similarly situated individuals that includes C but are not available to C. Thus, the benefits are not uniformly available to all similarly situated individuals. Even though the exclusionary rider is made effective the first day of the next plan year, because the rider does not apply to all similarly situated individuals, the issuer violates this paragraph (b)(2)(i).

Example 4. (i) Facts. A group health plan has a $2,000 lifetime limit for the treatment of temporomandibular joint syndrome (TMJ). The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) Conclusion. In this Example 4, the limit does not violate this paragraph (b)(2)(i) because coverage of the specific, non-essential health benefit up to $2,000 is 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. However, applying a lifetime limit on TMJ may violate §2590.715-2711, if TMJ coverage is an essential health benefit.
benefit, depending on the essential health benefits benchmark plan as defined in 45 CFR 156.20. This example does not address whether the plan provision is permissible under any other applicable law, including PHS Act section 2711 or the Americans with Disabilities Act.)

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. Additionally, this plan provision is prohibited under §2590.715-2711 because it imposes a lifetime limit on essential health benefits.

Example 6. (i) Facts. A group health plan limits benefits for prescription drugs to those listed on a drug formulary. The limit is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) Conclusion. In this Example 6, the exclusion from coverage of drugs not listed on the drug formulary does not violate this paragraph (b)(2)(i) because benefits for prescription drugs listed on the formulary are uniformly available to all similarly situated individuals and because the exclusion of drugs not listed on the formulary applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

Example 7. (i) Facts. Under a group health plan, doctor visits are generally subject to a $250 annual deductible and 20 percent coinsurance requirement. However, prenatal doctor visits are not subject to any deductible or coinsurance requirement. These rules are applied uniformly to all similarly situated individuals and are not directed at individual participants or beneficiaries.

(ii) Conclusion. In this Example 7, imposing different deductible and coinsurance requirements for prenatal doctor visits and other visits does not violate this paragraph (b)(2)(i) because a plan may establish different deductibles or coinsurance requirements for different services if the deductible or coinsurance requirement is applied uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries.

(ii) Exception for wellness programs. A group health plan or group health insurance issuer 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 or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). 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 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.)

(c) Prohibited discrimination in premiums or contributions—(1) In general—
(i) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in paragraph (d) of this section) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

(ii) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual’s premium or contribution rate. (For rules relating to cost-sharing mechanisms, see paragraph (b)(2) of this section (addressing benefits).)

(2) Rules relating to premium rates—(i) Group rating based on health factors not restricted under this section. Nothing in this section restricts the aggregate amount that an employer may be charged for coverage under a group health plan. But see §2590.702–1(b) of this Part, 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 insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see paragraph (g) of this section permitting favorable treatment of individuals with adverse health factors.)

(iii) Examples. The rules of this paragraph (c)(2) are illustrated by the following examples:

Example 1. (i) Facts. An employer sponsors a group health plan and purchases coverage from a health insurance issuer. In order to determine the premium rate for the upcoming plan year, the issuer reviews the claims experience of individuals covered under the plan. The issuer finds that Individual F had significantly higher claims experience than similarly situated individuals in the plan. The issuer quotes the plan a higher per-participant rate because of F’s claims experience.

(ii) Conclusion. In this Example 1, the issuer does not violate the provisions of this paragraph (c)(2) because the issuer blends the rate so that the employer is not quoted a higher rate for F than for a similarly situated individual based on F’s claims experience. (However, if the issuer used genetic information in computing the group rate, it would violate §2596.706–1(b) of this Part.)

(3) Exception for wellness programs. Notwithstanding paragraphs (c)(1) and (2) of this section, a plan or issuer 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 or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with the rules of this paragraph (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

(1) Participants. Subject to paragraph (d)(3) of this section, a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer’s usual business practice. Whether an employment-based classification is bona fide is determined on
the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to paragraph (d)(3) of this section, examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification, unless the requirements of paragraph (g) of this section are satisfied (permitting favorable treatment of individuals with adverse health factors).

(2) Beneficiaries—(i) Subject to paragraph (d)(3) of this section, a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

(A) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

(B) Relationship to the participant (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 children. However, coverage is made available to a child only if the child is under age 26 (or under age 29 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 children differently by imposing an age limitation on children, but not on spouses, is permitted under this paragraph (d).

Specifically, the distinction between spouses and 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 children who are under age 26 (or full-time students under age 29) as a group of similarly situated individuals separate from those who are age 26 or older (or age 29 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 higher deductible 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) General rule. Under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility (as described in paragraph (b)(1)(ii) of this section) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under the rules of paragraphs (b) and (c) of this section, a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under paragraphs (e)(2)(ii) and (3) of this section (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

(ii) Examples. The rules of this paragraph (e)(1) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, coverage for employees and their dependents generally becomes effective on the first day of employment. However, coverage for a dependent who is confined to a hospital or other health care institution does not become effective until the confinement ends.

(ii) Conclusion. In this Example 1, the plan violates this paragraph (e)(1) because the plan delays the effective date of coverage for dependents based on confinement to a hospital or other health care institution.

Example 2. (i) Facts. In previous years, a group health plan has provided coverage through a group health insurance policy offered by Issuer M. However, for the current year, the plan provides coverage through a group health insurance policy offered by Issuer N. Under Issuer N’s policy, items and services provided in connection with the confinement of a dependent to a hospital or other health care institution are not covered if the confinement is covered under an extension of benefits clause from a previous health insurance issuer.

(ii) Conclusion. In this Example 2, Issuer N violates this paragraph (e)(1) because the group health insurance coverage restricts benefits (a rule for eligibility under paragraph (b)(1)) based on whether a dependent is confined to a hospital or other health care institution that is covered under an extension of benefits clause from a previous issuer. State law cannot change the obligation of Issuer N under this section. However,
§2590.702
29 CFR Ch. XXV (7–1–15 Edition)

under State law Issuer M may also be responsible for providing benefits to such a dependent. In a case in which Issuer N has an obligation under this section 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—(1) 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)(i) of this section, a plan or issuer may not establish a rule for eligibility as described in paragraph (b)(1)(ii) of this section or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

(B) The rules of this paragraph (e)(2)(i) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, an employee generally becomes eligible to enroll 30 days after the first day of employment. However, if the employee is not actively at work on the first day after the end of the 30-day period, then eligibility for enrollment is delayed until the first day the employee is actively at work.

(ii) Conclusion. In this Example 1, the plan violates this paragraph (e)(2) (and thus also violates paragraph (b) of this section). However, the plan would not violate paragraph (e)(2) or (b) of this section if, under the plan, an absence due to any health factor is considered being actively at work.

Example 2. (i) Facts. Under a group health plan, coverage for an employee becomes effective after 90 days of continuous service; that is, if an employee is absent from work (for any reason) before completing 90 days of service, the beginning of the 90-day period is measured from the day the employee returns to work (without any credit for service before the absence).

(ii) Conclusion. In this Example 2, the plan violates this paragraph (e)(2) (and thus also paragraph (b) of this section) because the 90-day continuous service requirement is a rule for eligibility based on whether an individual is actively at work. However, the plan would not violate this paragraph (e)(2) or paragraph (b) of this section if, under the plan, an absence due to any health factor is not considered an absence for purposes of measuring 90 days of continuous service. (In addition, any eligibility provision that is time-based must comply with the requirements of PHS Act section 2708 and its implementing regulations.)

(1) Exception for the first day of work—(A) Notwithstanding the general rule in paragraph (e)(2)(i) of this section, a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

(B) The rules of this paragraph (e)(2)(ii) are illustrated by the following examples:

Example 1. (i) Facts. Under the eligibility provision of a group health plan, coverage for new employees becomes effective on the first day that the employee reports to work. Individual H is scheduled to begin work on April 7 and J’s coverage is effective on April 7. However, H is unable to begin work on that day because of illness. H begins working on August 4, and J’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—(1) Notwithstanding the rules of paragraphs (e)(1) and (2) of this section, a
plan or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in paragraph (d) of this section. Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to paragraph (d) of this section. However, other Federal or State laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services.

(ii) The rules of this paragraph (e)(3) are illustrated by the following examples:

Example 1. (i) Facts. Under a group health plan, employees are eligible for coverage if they perform services for the employer for 30 or more hours per week or if they are on paid leave (such as vacation, sick, or bereavement leave). Employees on unpaid leave are treated as a separate group of similarly situated individuals in accordance with the rules of paragraph (d) of this section. 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) 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 also would violate paragraph (b) of this section because groups of similarly situated individuals cannot be established based on a health factor (including the taking of sick leave) under paragraph (d) of this section.

Example 2. (i) Facts. To be eligible for coverage under a bona fide collectively bargained group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the three-month period that ends one month before the beginning of the current calendar quarter. The distinction between employees working at least 250 hours and those working less than 250 hours in the earlier three-month period is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.

(ii) Conclusion. In this Example 2, the plan provision does not violate this section because, under the rules for similarly situated individuals allowing full-time employees to be treated differently than part-time employees, employees who work at least 250 hours in a three-month period can be treated differently than employees who fail to work 250 hours in that period. The result would be the same if the plan permitted individuals to apply excess hours from previous periods to satisfy the requirement for the current quarter.

Example 3. (i) Facts. Under a group health plan, coverage of an employee is terminated when the individual's employment is terminated, in accordance with the rules of paragraph (d) of this section. Employee B has been covered under the plan. B experiences a disabling illness that prevents B from working. B takes a leave of absence under the Family and Medical Leave Act of 1993. At the end of such leave, B terminates employment and consequently loses coverage under the plan. This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.

(ii) Conclusion. In this Example 3, the plan provision terminating B's coverage upon B's termination of employment does not violate this section.

Example 4. (i) Facts. Under a group health plan, coverage of an employee is terminated when the employee ceases to perform services for the employer sponsoring the plan, in accordance with the rules of paragraph (d) of this section. Employee C is laid off for three months. When the layoff begins, C's coverage under the plan is terminated. This termination of coverage is without regard to whatever rights the employee (or members of the employee's family) may have for COBRA continuation coverage.

(ii) Conclusion. In this Example 4, the plan provision terminating C's coverage upon the cessation of C's performance of services does not violate this section.

(f) Nondiscriminatory wellness programs—in general. A wellness program is a program of health promotion or disease prevention. 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).
(1) **Definitions.** The definitions in this paragraph (f)(1) govern in applying the provisions of this paragraph (f).

(i) **Reward.** Except where expressly provided otherwise, references in this section to an individual obtaining a reward include both obtaining a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and avoiding a penalty (such as the absence of a premium surcharge or other financial or nonfinancial disincentive). References in this section to a plan providing a reward include both providing a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and imposing a penalty (such as a surcharge or other financial or nonfinancial disincentive).

(ii) **Participatory wellness programs.** 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 (or if a wellness program does not provide a reward), the wellness program is a participatory wellness program. Examples of participatory wellness programs are:

(A) A program that reimburses employees for all or part of the cost for membership in a fitness center.

(B) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes.

(C) 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. (Note that, with respect to non-grandfathered plans, §2590.715–2713 of this part requires benefits for certain preventive health services without the imposition of cost sharing.)

(D) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.

(E) A program that provides a reward to employees for attending a monthly, no-cost health education seminar.

(F) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment. (See also §2590.702–1 for rules prohibiting collection of genetic information.)

(iii) **Health-contingent wellness programs.** A health-contingent wellness program is a program that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). A health-contingent wellness program may be an activity-only wellness program or an outcome-based wellness program.

(iv) **Activity-only wellness programs.** An activity-only wellness program is a type of health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). A health-contingent wellness program typically has two tiers. That is, for individuals who do not attain or maintain a specific health outcome, compliance with an educational program or an activity may be offered as

(v) **Outcome-based wellness programs.** An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. To comply with the rules of this paragraph (f), an outcome-based wellness program typically has two tiers. That is, for individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as
an alternative to achieve the same re-
ward. This alternative pathway, how-
ever, does not mean that the overall pro-
gram, which has an outcome-based com-
ponent, is not an outcome-based wellness program. That is, if a mea-
surement, test, or screening is used as part of an initial standard and individ-
uals who meet the standard are grant-
ed the reward, the program is consid-
ered an outcome-based wellness pro-
gram. For example, if a wellness pro-
gram tests individuals for specified medical conditions or risk factors (in-
cluding biometric screening such as test-
ing for high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a re-
ward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range (or at risk) to take addi-
tional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improve-
ment action plan, complying with a walking or exercise program, or com-
plying with a health care provider’s plan of care) to obtain the same re-
ward, the program is an outcome-based wellness program. See para-
graph (f)(4) of this section for requirements appli-
cable to outcome-based wellness pro-
grams.

(2) Requirement for participatory wellness programs. A participatory wellness program, as described in para-
graph (f)(1)(ii) of this section, does not violate the provisions of this section only if participation in the program is made available to all similarly situ-
ated individuals, regardless of health status.

(3) Requirements for activity-only wellness programs. A health-contingent wellness program that is an activity-
only wellness program, as described in para-
graph (f)(1)(iv) of this section, does not violate the provisions of this sec-
tion only if all of the following require-
ments are satisfied:

(i) Frequency of opportunity to qualify. The program must give individuals eli-
gible for the program the opportunity to qualify for the reward under the pro-
gram at least once per year.

(ii) Size of reward. The reward for the activity-only wellness program, to-
gether with the reward for other health-contingent wellness programs with respect to the plan, must not ex-
ceed the applicable percentage (as de-
fined in paragraph (f)(5) of this section) of the total cost of employee-only cov-
erage under the plan. However, if, in addition to employees, any class of de-
pendents (such as spouses, or spouses and dependent children) may partici-
pate in the wellness program, the re-
ward must not exceed the applicable percentage of the total cost of the cov-
erage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(3)(ii), the cost of coverage is determined based on the total amount of employer and em-
ployee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) re-
ceiving coverage.

(iii) Reasonable design. The program must be reasonably designed to pro-
mote health or prevent disease. A pro-
gram satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, par-
ticipating 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. This determination is based on all the relevant facts and cir-
cumstances.

(iv) Uniform availability and reasonable alternative standards. The full reward under the activity-only wellness pro-
gram must be available to all similarly situ-
ated individuals.

(A) Under this paragraph (f)(3)(iv), a reward under an activity-only wellness pro-
gram is not available to all similarly situ-
ated individuals for a period unless the program meets both of the fol-
lowing requirements:

(1) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for ob-
taining the reward for any individual for whom, for that period, it is unre-
asonably difficult due to a medical con-
dition to satisfy the otherwise applica-
ble standard; and
§ 2590.702

(2) The program allows 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) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in either paragraph (f)(3)(iv)(A)(1) or (2) of this section, a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

(C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

(I) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

(2) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

(3) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

(4) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

(D) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this paragraph (f)(3) in the same manner as if it were an initial program standard. (Thus, for example, if a plan or issuer provides a walking program as a reasonable alternative standard to a running program, individuals for whom it is unreasonably difficult due to a medical condition to complete the walking program (or for whom it is medically inadvisable to attempt to complete the walking program) must be provided a reasonable alternative standard to the walking program.) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of paragraph (f)(4) of this section, including paragraph (f)(4)(iv)(D).

(E) If reasonable under the circumstances, a plan or issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an activity-only wellness program. Plans and issuers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request.

(v) Notice of availability of reasonable alternative standard. The plan or issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in paragraph (f)(6)
of this section, as well as in certain examples of this section.

(vi) Example. The provisions of this paragraph (f)(3) are illustrated by the following example:

Example. (i) Facts. A group health plan provides a reward to individuals who participate in a reasonable specified walking program. If it is unreasonably difficult due to a medical condition for an individual to participate (or if it is medically inadvisable for an individual to attempt to participate), the plan will waive the walking program requirement and provide the reward. All materials describing the terms of the walking program disclose the availability of the waiver.

(ii) Conclusion. In this Example, the program satisfies the requirements of paragraph (f)(3)(iii) of this section because the walking program is reasonably designed to promote health and prevent disease. The program satisfies the requirements of paragraph (f)(3)(iv) of this section because the reward under the program is available to all similarly situated individuals. It accommodates individuals for whom it is unreasonably difficult to participate in the walking program due to a medical condition (or for whom it would be medically inadvisable to attempt to participate) by providing them with the reward even if they do not participate in the walking program (that is, by waiving the condition). The plan also complies with the disclosure requirement of paragraph (f)(3)(v) of this section. Thus, the plan satisfies paragraphs (f)(3)(iii), (iv), and (v) of this section.

(4) Requirements for outcome-based wellness programs. A health-contingent wellness program that is an outcome-based wellness program, as described in paragraph (f)(1)(v) of this section, does not violate the provisions of this section only if all of the following requirements are satisfied:

(i) Frequency of opportunity to qualify. The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

(ii) Size of reward. The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in paragraph (f)(5) of this section) of the total 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 the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph (f)(4)(ii), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

(iii) Reasonable design. 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. This determination is based on all the relevant facts and circumstances. To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test, or screening that is related to a health factor, as explained in paragraph (f)(4)(iv) of this section.

(iv) Uniform availability and reasonable alternative standards. The full reward under the outcome-based wellness program must be available to all similarly situated individuals.

(A) Under this paragraph (f)(4)(iv), a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test, or screening, as described in this paragraph (f)(4)(iv).

(B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual’s request for
one, if an individual is described in paragraph (f)(4)(iv)(A) of this section, a reasonable alternative standard must be furnished by the plan or issuer upon the individual’s request or the condition for obtaining the reward must be waived.

(C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

(1) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

(2) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

(3) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

(4) If an individual’s personal physician states that a plan standard (including, if applicable, the recommendations of the plan’s medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual’s personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician’s recommendations.

(D) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of paragraph (f)(3) of this section in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this paragraph (f)(4), subject to the following special provisions:

(1) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual’s circumstances. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. However, if the initial standard is to achieve a BMI less than 30, a reasonable alternative standard for the individual could be to reduce the individual’s BMI by a small amount or small percentage, over a realistic period of time, such as within a year.

(2) An individual must be given the opportunity to comply with the recommendations of the individual’s personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician’s recommendations at any time and the personal physician can adjust the physician’s recommendations at any time, consistent with medical appropriateness.

(E) It is not reasonable to seek verification, such as a statement from an individual’s personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. However, if a plan or issuer provides an alternative standard to the otherwise applicable measurement, test, or screening that involves an activity that is related to a health factor, then the rules of paragraph (f)(3) of this section for activity-only wellness programs apply to that component of the wellness program and the plan or issuer may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or
complete the activity (or it is medically inadvisable to attempt to perform or complete the activity). (For example, if an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a diet and exercise program for individuals who do not meet the targeted weight, a plan or issuer may seek verification, as described in paragraph (f)(3)(iv)(D) of this section, if reasonable under the circumstances, that a second reasonable alternative standard is needed for certain individuals because, for those individuals, it would be unreasonably difficult due to a medical condition to comply, or medically advisable to attempt to comply, with the diet and exercise program, due to a medical condition.)

(v) Notice of availability of reasonable alternative standard. The plan or issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual’s personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in paragraph (f)(6) of this section, as well as in certain examples of this section.

(vi) Examples. The provisions of this paragraph (f)(4) are illustrated by the following examples:

Example 1—Cholesterol screening with reasonable alternative standard to work with personal physician. (i) Facts. A group health plan offers a reward to participants who achieve a count under 200 on a total cholesterol test. If a participant does not achieve the targeted cholesterol count, the plan allows the participant to develop an alternative cholesterol action plan in conjunction with the participant’s personal physician that may include recommendations for medication and additional screening. The plan allows the physician to modify the standards, as medically necessary, over the year. (For example, if a participant develops asthma or depression, requires surgery and convalescence, or some other medical condition or consideration makes completion of the original action plan inadvisable or unreasonably difficult, the physician may modify the original action plan.) All plan materials describing the terms of the program include the following statement: “Your health plan wants to help you take charge of your health. Rewards are available to all employees who participate in our Cholesterol Awareness Wellness Program. If your total cholesterol count is under 200, you will receive the reward. If not, you will still have an opportunity to qualify for the reward. We will work with you and your doctor to find a Health Smart program that is right for you.” In addition, when any individual participant receives notification that his or her cholesterol count is 200 or higher, the notification includes the following statement: “Your plan offers a Health Smart program under which we will work with you and your doctor to try to lower your cholesterol. If you complete this program, you will qualify for a reward. Please contact us at [contact information] to get started.”

(ii) Conclusion. In this Example 1, the program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain cholesterol level) to obtain a reward. The program satisfies the requirements of paragraph (f)(4)(iii) of this section because the cholesterol program is reasonably designed to promote health and prevent disease. The program satisfies the requirements of paragraph (f)(4)(iv) of this section because it makes available to all participants who do not meet the cholesterol standard a reasonable alternative standard to qualify for the reward. Lastly, the plan also discloses in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard the availability of a reasonable alternative standard (including contact information and the individual’s ability to involve his or her personal physician), as required by paragraph (f)(4)(v) of this section. Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 2—Cholesterol screening with plan alternative and no opportunity for personal physician involvement. (i) Facts. Same facts as Example 1, except that the wellness program’s physician or nurse practitioner (rather than the individual’s personal physician) determines the alternative cholesterol action plan. The plan does not provide an opportunity for a participant’s personal physician to modify the action plan if it is not medically appropriate for that individual.
(i) Conclusion. In this Example 2, the wellness program does not satisfy the requirements of paragraph (f)(4)(iii) of this section because the program does not accommodate the participant’s personal physician with regard to medical appropriateness, as required under paragraph (f)(4)(iv)(C)(3) of this section. Thus, the program is not reasonably designed under paragraph (f)(4)(iii) of this section and is not available to all similarly situated individuals under paragraph (f)(4)(iv) of this section. The notice also does not provide all the content required under paragraph (f)(4)(v) of this section.

Example 3—Cholesterol screening with plan alternative that can be modified by personal physician. (i) Facts. Same facts as Example 2, except that if a participant’s personal physician disagrees with any part of the action plan, the personal physician may modify the action plan at any time, and the plan discloses this to participants.

(ii) Conclusion. In this Example 3, the wellness program satisfies the requirements of paragraph (f)(4)(iii) of this section because the participant’s personal physician may modify the action plan determined by the wellness program’s physician or nurse practitioner at any time if the physician states that the recommendations are not medically appropriate, as required under paragraph (f)(4)(iv)(C)(3) of this section. Thus, the program is reasonably designed under paragraph (f)(4)(iii) of this section and is available to all similarly situated individuals under paragraph (f)(4)(iv) of this section. The notice, which includes a statement that recommendations of an individual’s personal physician will be accommodated, also complies with paragraph (f)(4)(v) of this section.

Example 4—BMI screening with walking program alternative. (i) Facts. A group health plan will provide a reward to participants who have a body mass index (BMI) that is 26 or lower, determined shortly before the beginning of the year. Any participant who does not meet the target BMI is given the same discount if the participant complies with an exercise program that consists of walking 150 minutes a week. Any participant for whom it is medically inadvisable to attempt to comply with the walking program during the year is given the same discount if the participant satisfies an alternative standard that is reasonable taking into consideration the participant’s medical situation, is not unreasonably burdensome or impractical to comply with, and is otherwise reasonably designed based on all the relevant facts and circumstances. All plan materials describing the terms of the wellness program include the following statement: “Fitness is Easy! Start Walking! Your health plan cares about your health. If you are considered overweight because you have a BMI of over 26, our Start Walking program will help you lose weight and feel better. We will help you enroll. ***If your doctor says that walking isn’t right for you, that’s okay too. We will work with you (and, if you wish, your own doctor) to develop a wellness program that satisfies the requirements of paragraphs (f)(4)(iv) and (v) of this section. Nevertheless, it is unreasonably difficult due to a medical condition for E to comply with the walking program. E proposes a program based on the recommendations of E’s physician. The plan agrees to make the same discount available to E that is available to other participants in the BMI program or the alternative walking program, but only if E actually follows the physician’s recommendations.

(ii) Conclusion. In this Example 4, the program is an outcome-based wellness program because the initial standard requires an individual to attain or maintain a specific health outcome (a certain BMI level) to obtain a reward. The program satisfies the requirements of paragraph (f)(4)(iii) of this section because it is reasonably designed to promote health and prevent disease. The program also satisfies the requirements of paragraph (f)(4)(iv) of this section because it makes available to all individuals who do not satisfy the BMI standard a reasonable alternative standard to qualify for the reward (in this case, a walking program that is not unreasonably burdensome or impractical for individuals to comply with and that is otherwise reasonably designed based on all the relevant facts and circumstances). In addition, the walking program is, itself, an activity-only standard and the plan complies with the requirements of paragraph (f)(3)(v) that, if there are individuals for whom it is unreasonably difficult due to a medical condition to comply, or for whom it is medically inadvisable to attempt to comply with the walking program, the plan provide a reasonable alternative to those individuals. Moreover, the plan satisfies the requirements of paragraph (f)(4)(v) of this section because it discloses, in all materials describing the terms of the program and in any disclosure that an individual did not satisfy the initial outcome-based standard, the availability of a reasonable alternative standard (including contact information and the individual’s option to involve his or her personal physician) to qualify for the reward or the possibility of waiver of the otherwise applicable standard. Thus, the program satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v) of this section.

Example 5—BMI screening with alternatives available to either lower BMI or meet personal
physician’s recommendations. (i) Facts. Same facts as Example 4 except that, with respect to any participant who does not meet the target BMI, instead of a walking program, the plan is expected to reduce BMI by one point. At any point during the year upon request, any individual can obtain a second reasonable alternative standard, which is consistent with the recommendations of the participant’s personal physician regarding weight, diet, and exercise as set forth in a treatment plan that the physician recommends or to which the physician agrees. The participant’s personal physician is permitted to change or adjust the treatment plan at any time and the option of following the participant’s personal physician’s recommendations is clearly disclosed.

(ii) Conclusion. In this Example 5, the reasonable alternative standard to qualify for the reward (the alternative BMI standard requiring a one-point reduction) does not make the program unreasonable under paragraph (f)(4)(iii) or (iv) of this section because the program complies with paragraph (f)(4)(iv)(C)(4) of this section by allowing a second reasonable alternative standard to qualify for the reward (compliance with the recommendations of the participant’s personal physician, which can be changed or adjusted at any time). Accordingly, the program continues to satisfy the applicable requirements of paragraph (f) of this section.

Example 6—Tobacco use surcharge with smoking cessation program alternative. (i) Facts. In conjunction with an annual open enrollment period, a group health plan provides a premium differential based on tobacco use, determined using a health risk assessment. The following statement is included in all plan materials describing the tobacco premium differential: ‘‘Stop smoking today! We can help! If you are a smoker, we offer a smoking cessation program. If you complete the program, you can avoid this surcharge.’’ The plan accommodates participants who smoke by facilitating their enrollment in a smoking cessation program that requires participation at a time and place that are not unreasonably burdensome or impractical for participants, and that is otherwise reasonably designed based on all the relevant facts and circumstances, and discloses contact information and the individual’s option to involve his or her personal physician. The plan pays for the cost of participation in the smoking cessation program. Any participant who can avoid the surcharge for the plan year by participating in the program, regardless of whether the participant stops smoking, but the plan can require a participant who wants to avoid the surcharge in a subsequent year to complete the smoking cessation program again.

(ii) Conclusion. In this Example 6, the premium differential satisfies the requirements of paragraphs (f)(4)(iii), (iv), and (v). The program is an outcome-based wellness program because the initial standard for obtaining a reward is dependent on the results of a health risk assessment (a measurement, test, or screening). The program is reasonably designed under paragraph (f)(4)(iii) because the plan provides a reasonable alternative standard (as required under paragraph (f)(4)(iv) of this section) to qualify for the reward to all tobacco users (a smoking cessation program). The plan discloses, in all materials describing the terms of the program, the availability of the reasonable alternative standard (including contact information and the individual’s option to involve his or her personal physician). Thus, the program satisfies the requirements of paragraphs (f)(4)(ii), (iv), and (v) of this section.

Example 7—Tobacco use surcharge with alternative program requiring actual cessation. (i) Facts. Same facts as Example 6, except the plan does not provide participant F with the reward in subsequent years unless F actually stops smoking after participating in the tobacco cessation program.

(ii) Conclusion. In this Example 7, the program is not reasonably designed under paragraph (f)(4)(iii) of this section and does not provide a reasonable alternative standard as required under paragraph (f)(4)(iv) of this section. The plan cannot cease to provide a reasonable alternative standard merely because the participant did not stop smoking after participating in a smoking cessation program. The plan must continue to offer a reasonable alternative standard whether it is the same or different (such as a new recommendation from F’s personal physician or a new nicotine replacement therapy).

Example 8—Tobacco use surcharge with smoking cessation program alternative that is not reasonable. (i) Facts. Same facts as Example 6, except the plan does not facilitate participant F’s enrollment in a smoking cessation program. Instead the plan advises F to find a program, pay for it, and provide a certificate of completion to the plan.

(ii) Conclusion. In this Example 8, the requirement for F to find and pay for F’s own smoking cessation program means that the alternative program is not reasonable. Accordingly, the plan has not offered a reasonable alternative standard that complies with paragraphs (f)(4)(iii) and (iv) of this section and the program fails to satisfy the requirements of paragraph (f) of this section.

(5) Applicable percentage—(i) For purposes of this paragraph (f), the applicable percentage is 30 percent, except that the applicable percentage is increased by an additional 20 percentage points (to 50 percent) to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use.
(ii) The rules of this paragraph (f)(5) 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 $6,000 (of which the employer pays $4,500 per year and the employee pays $1,500 per year). The plan offers employees a health-contingent wellness program with several components, focused on exercise, blood sugar, weight, cholesterol, and blood pressure. The reward for compliance is an annual premium rebate of $600.

(ii) Conclusion. In this Example 1, the reward for the wellness program, $600, does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage, $1,800. ($6,000 × 30% = $1,800.)

Example 2. (i) Facts. Same facts as Example 1, except the wellness program is exclusively a tobacco prevention program. Employees who have used tobacco in the last 12 months and who are not enrolled in the plan’s tobacco cessation program are charged a $1,000 premium surcharge (in addition to their employee contribution towards the coverage). (Those who participate in the plan’s tobacco cessation program are not assessed the $1,000 surcharge.)

(ii) Conclusion. In this Example 2, the reward for the wellness program (absence of a $1,000 surcharge), does not exceed the applicable percentage of 50 percent of the total annual cost of employee-only coverage, $3,000. ($6,000 × 50% = $3,000.)

Example 3. (i) Facts. Same facts as Example 1, except that, in addition to the $600 reward for compliance with the health-contingent wellness program, the plan also imposes an additional $2,000 tobacco premium surcharge on employees who have used tobacco in the last 12 months and who are not enrolled in the plan’s tobacco cessation program. (Those who participate in the plan’s tobacco cessation program are not assessed the $2,000 surcharge.)

(ii) Conclusion. In this Example 3, the total of all rewards (including absence of a surcharge for participating in the tobacco program) is $2,500 ($600 + $2,000 = $2,500), which does not exceed the applicable percentage of 50 percent of the total annual cost of employee-only coverage ($3,000); and, tested separately, the $600 reward for the wellness program unrelated to tobacco use does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage ($1,800).

Example 4. (i) Facts. An employer sponsors a group health plan. The total annual premium for employee-only coverage (including both employer and employee contributions towards the coverage) is $5,000. The plan provides a $250 reward to employees who complete a health risk assessment, without regard to the health issues identified as part of the assessment. The plan also offers a Healthy Heart program, which is a health-contingent wellness program, with an opportunity to earn a $1,500 reward.

(ii) Conclusion. In this Example 4, even though the total reward for all wellness programs under the plan is $1,750 ($250 + $1,500 = $1,750, which exceeds the applicable percentage of 30 percent of the cost of the annual premium for employee-only coverage ($5,000 × 30% = $1,500)), only the reward offered for compliance with the health-contingent wellness program ($1,500) is taken into account in determining whether the rules of this paragraph (f)(5) are met. (The $250 reward is offered in connection with a participatory wellness program and therefore is not taken into account.) Accordingly, the health-contingent wellness program offers a reward that does not exceed the applicable percentage of 30 percent of the total annual cost of employee-only coverage.

(6) Sample language. The following language, or substantially similar language, can be used to satisfy the notice requirement of paragraphs (f)(3)(v) or (f)(4)(v) of this section: “Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.”

(g) More favorable treatment of individuals with adverse health factors permitted.—(1) In rules for eligibility.—(i) Nothing in this section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in paragraph (b)(1) of this section) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including State insurance laws, may set or limit
premium rates: these laws are not affected by this section.)

(ii) The rules of this paragraph (g)(1) are illustrated by the following examples:

Example 1. (i) Facts. An employer sponsors a group health plan that generally is available to employees, spouses of employees, and dependent children until age 26. However, dependent children who are disabled are eligible for coverage beyond age 26.

(ii) Conclusion. In this Example 1, the plan provision allowing coverage for disabled dependent children beyond age 26 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 individuals 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. The plan could likewise charge the disabled individuals a higher premium for the extended coverage.

(2) In premiums or contributions—(i) Nothing in this section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability.

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

Example. (i) Facts. Under a group health plan, employees are generally required to pay $50 per month for employee-only coverage and $125 per month for family coverage under the plan. However, employees who are disabled receive coverage (whether employee-only or family coverage) under the plan free of charge.

(ii) Conclusion. In this Example, the plan provision waiving premium payment for disabled employees is permitted under this paragraph (g)(2) (and thus does not violate this section).

(h) No effect on other laws. Compliance with this section is not determinative of compliance with any other provision of the Act (including the COBRA continuation provisions) or any other State or Federal law, such as the Americans with Disabilities Act. Therefore, although the rules of this section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other Federal or State laws may require that two separate groups of similarly situated individuals be treated the same for certain
purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this section generally does not impose new disclosure obligations on plans and issuers, this section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation.

(i) Applicability dates. This section applies for plan years beginning on or after July 1, 2007.

§ 2590.702–1 Additional requirements prohibiting discrimination based on genetic information.

(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 § 2590.701–2 of this Part) 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 new-born 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. The diagnosis is not manifested with respect to a 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, and a health insurance issuer offering health insurance coverage in connection with a group health plan, must not adjust premium or contribution amounts for the plan, 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 §2590.702(d) of this Part.

(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 health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for a group health plan or 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 a group health plan 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 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. In this Example 1, the issuer violates the provisions 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, it is permissible for the issuer to increase 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, and a health insurance issuer offering health insurance coverage in connection with 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 (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 or issuer 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 or issuer 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 or issuer is permitted to condition payment for the item or service on the outcome of a genetic test. The plan or issuer may also refuse payment if the patient does not undergo the genetic test.

(ii) Limitation. A plan or issuer 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 or issuer 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 or issuer 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 or issuer makes the request in writing, and the request clearly indicates to each participant or beneficiary (or, in the case of a minor child, 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 §2590.702(b)(1) of this Part) 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 or issuer 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, and a health insurance issuer offering health insurance coverage in connection with 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 §2590.702(b)(1)(ii) of this Part (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 pre-existing 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 or health insurance coverage, the plan or coverage 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 or issuer 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 or issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness. The plan or issuer 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)(i) 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, and a health insurance issuer offering health insurance coverage in connection with 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 or coverage, nor in connection with the rules for eligibility (as defined in §2590.702(b)(1)(ii) of this Part) 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, or a health insurance issuer offering health insurance coverage in connection with 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 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.

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 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 requests N’s records, stating that N should not provide genetic information and should review the records to excise any genetic information. N, after reviewing the records, requests the genetic information be excised from the records. The issuer is permitted to request only the minimum amount of information necessary to make a decision regarding payment, provided the plan requests only the minimum amount of genetic information necessary to make the determination. 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 CYP2D6 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 paragraphs (c) or (d) 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 CYP2D6 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) Applicability date. This section applies for plan years beginning on or after December 7, 2009.

[74 FR 51683, Oct. 7, 2009]
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 or issuer is prohibited from requiring that a physician or other health care provider obtain authorization from the plan or issuer 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 designated 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 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, and a health insurance issuer offering group health insurance coverage, may not—

(A) Deny a mother or her newborn child eligibility or continued eligibility to enroll or renew coverage under the terms of the plan solely to avoid the requirements of this section; or

(B) Provide payments (including payments-in-kind) or rebates to a mother to encourage her to accept less than the minimum protections available under this section.
(i) 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 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, and a health insurance issuer offering group health insurance coverage, may not restrict the benefits for any portion of a hospital length of stay specified in paragraph (a)(3) 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, and a health insurance issuer offering group health insurance coverage, may not directly or indirectly—

(i) Penalize (for example, take disciplinary action against or retaliate against), or otherwise reduce or limit the compensation of, an attending provider because the provider furnished care to a participant or beneficiary in accordance with this section; or

(ii) Provide monetary or other incentives to an attending provider to induce the provider to furnish care to a participant or beneficiary in a manner inconsistent with this section, including providing any incentive that could induce an attending provider to discharge a mother or newborn earlier than 48 hours (or 96 hours) after delivery.

(c) Construction. With respect to this section, the following rules of construction apply:

(1) Hospital stays not mandatory. This section does not require a mother to—

(i) Give birth in a hospital; or

(ii) Stay in the hospital for a fixed period of time following the birth of her child.

(2) Hospital stay benefits not mandated. This section does not apply to any group health plan, or any group health insurance coverage, that does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.
§2590.711

(3) Cost-sharing rules—(i) In general. This section does not prevent a group health plan or a health insurance issuer offering group health insurance coverage from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn under the plan or coverage, except that the coinsurance or other cost-sharing for any portion of the hospital length of stay 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 or a health insurance issuer offering group health insurance coverage from negotiating with an attending provider the level and type of compensation for care furnished in accordance with this section (including paragraph (b) of this section).

(d) Notice requirement. See 29 CFR 2520.102–3(u) (relating to the disclosure requirement under section 711(d) of the Act).

(e) Applicability in certain states—(1) Health insurance coverage. The requirements of section 711 of the Act and this section do not apply with respect to health insurance coverage offered in connection with a group health plan if there is a state law regulating the coverage that meets any of the following criteria:

(i) The state law requires the coverage to provide for at least a 48-hour hospital length of stay following a vaginal delivery and at least a 96-hour hospital length of stay following a delivery by 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 criteria of this paragraph (e)(1)(iii).

(2) Group health plans—(i) Fully-insured plans. For a group health plan that provides benefits solely through health insurance coverage, if the state law regulating the health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section do not apply.

(ii) Self-insured plans. For a group health plan that provides all benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage, the requirements of section 711 of the Act and this section apply.

(iii) Partially-insured plans. For a group health plan that provides some benefits through health insurance coverage, if the state law regulating the
health insurance coverage meets any of the criteria in paragraph (e)(1) of this section, then the requirements of section 711 of the Act and this section apply only to the extent the plan provides benefits for hospital lengths of stay in connection with childbirth other than through health insurance coverage.

(3) Relation to section 731(a) of the Act. The preemption provisions contained in section 731(a)(1) of the Act and Sec. 2590.731(a) do not supersede a state law described in paragraph (e)(1) of this section.

(4) Examples. The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) 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 711 of the Act 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 711 of the Act and this section.

(f) Applicability date. This section applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 2009.

[73 FR 62422, Oct. 20, 2008]

§2590.712 Parity in mental health and substance use disorder benefits.

(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 (or health insurance coverage offered in connection with such a 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 (or health insurance coverage offered in connection with such a 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 with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage 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 items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage 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 items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage 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 or coverage. (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 for purposes of this definition.

(b) Parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of PHS Act section 2711, as incorporated in ERISA section 715 and Code section 9815, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits. For more information, see 29 CFR 2590.715-2711.

(1) General—(i) General parity requirement. A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan (or health insurance coverage) 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 (or health insurance coverage) 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 (or health insurance coverage) 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) 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.

(5) Plan not described in paragraph (b)(2) or (b)(3) of this section—(i) In general. A group health plan (or health insurance coverage) 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 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 on 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)(5)(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)(5), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(4) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(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)(i) 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.
§ 2590.712

(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 (or health insurance coverage) 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 (or health insurance coverage offered by an issuer in connection with 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 non-quantitative 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 (or health insurance coverage) 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 (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan (or health insurance coverage) 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 (illustrated in examples in paragraph (c)(2)(ii)(C) of this section). 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 or health insurance coverage. See special rules for plans with multiple network tiers in paragraph (c)(3)(iii) of this section.

(2) Inpatient, out-of-network. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) 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 or health insurance coverage. See special rules for office visits and plans with multiple network tiers in paragraph (c)(3)(iii) of this section.

(4) Outpatient, out-of-network. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers. See special rules for office visits in paragraph (c)(3)(iii) of this section.


(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 (or
health insurance coverage) 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 care, 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 care 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—(I) 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 (or health insurance issuer) 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 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. (See also PHS Act section 2707(b) and Affordable Care Act section 1302(c), which establish limitations on annual deductibles for non-grandfathered health plans in the small group market and annual limitations on out-of-pocket maximums for all non-grandfathered health plans.)

(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).

(i) Application to different coverage units. If a plan (or health insurance coverage) 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.

(ii) Special rules—(A) Multi-tiered prescription drug benefits. If a plan (or health insurance coverage) 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 non-quantitative 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 (or health insurance coverage) 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.

(B) Multiple network tiers. If a plan (or health insurance coverage) provides benefits through multiple tiers of in-
network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits. After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

(I) Office visits (such as physician visits), and

(2) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

(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:

<table>
<thead>
<tr>
<th>Coinsurance rate ..........</th>
<th>0%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>30%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected payments ..........</td>
<td>$200x</td>
<td>$100x</td>
<td>$450x</td>
<td>$100x</td>
<td>$150x</td>
<td>$1,000x</td>
</tr>
<tr>
<td>Percent of total plan costs</td>
<td>20%</td>
<td>10%</td>
<td>45%</td>
<td>10%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Percent subject to coinsurance level</td>
<td>N/A</td>
<td>12.5%</td>
<td>18.75%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(100x)</td>
<td>(500x)</td>
<td>(500x)</td>
<td>(500x)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Copayment amount</th>
<th>$0</th>
<th>$10</th>
<th>$15</th>
<th>$20</th>
<th>$50</th>
<th>Total.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected payments</td>
<td>$200x</td>
<td>$200x</td>
<td>$200x</td>
<td>$300x</td>
<td>$100x</td>
<td>$1,000x</td>
</tr>
<tr>
<td>Percent of total plan costs.</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>30%</td>
<td>10%</td>
<td>100%</td>
</tr>
<tr>
<td>Percent subject to copayments.</td>
<td>N/A</td>
<td>25%</td>
<td>25%</td>
<td>37.5%</td>
<td>12.5%</td>
<td></td>
</tr>
</tbody>
</table>

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%; for the $15 copayment, 25%; for the $20 copayment, 37.5%; and for the $50 copayment, 12.5%). 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 copayment ($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).

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier description</td>
<td>Generic drugs</td>
<td>Preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)</td>
<td>Non-preferred brand name drugs</td>
</tr>
<tr>
<td>Percent paid by plan</td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

(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 meets 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).

Example 5. (i) Facts. A plan has two tiers of network of providers: a preferred provider tier and a participating provider tier. Provider tier placement is determined in accordance with the rules in paragraph (c)(4) of this section, such as according to the provider’s experience, quality, and performance measures (including customer feedback), and relative reimbursement rates. Furthermore, provider tier placement is determined without regard to whether a provider specializes in the treatment of mental health conditions or substance use disorders, or medical/surgical conditions. The plan divides the in-network classifications into two sub-classifications (in-network/preferred and in-network/participating). The plan does not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) Conclusion. In this Example 5, the division of in-network benefits into sub-classifications that reflect the preferred and participating provider tiers does not violate the parity requirements of this paragraph (c)(3).

Example 6. (i) Facts. With respect to outpatient, in-network benefits, a plan imposes a $25 copayment for office visits and a 20 percent coinsurance requirement for outpatient surgery. The plan divides the outpatient, in-network classification into two sub-classifications (in-network office visits and all other outpatient, in-network items and services). The plan or issuer does not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in either of these sub-classifications that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in each sub-classification.

(ii) Conclusion. In this Example 6, the division of outpatient, in-network benefits into sub-classifications for office visits and all other outpatient, in-network items and services does not violate the parity requirements of this paragraph (c)(3).

Example 7. (i) Facts. Same facts as Example 6, but for purposes of determining parity, the plan divides the outpatient, in-network classification into outpatient, in-network generalists and outpatient, in-network specialists. (ii) Conclusion. In this Example 7, the division of outpatient, in-network benefits into any sub-classifications other than office visits and all other outpatient items and services violates the requirements of paragraph (c)(3)(iii)(C) of this section.

(v) No separate cumulative financial requirements or cumulative quantitative treatment limitations.—(A) A group health plan (or health insurance coverage offered in connection with 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:
(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 (or health insurance coverage) 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 (or health insurance coverage) 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.

(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 investigatory;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards for provider admission to participate in a network, including reimbursement rates;

(E) Plan methods for determining usual, customary, and reasonable charges;

(F) 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);

(G) Exclusions based on failure to complete a course of treatment; and

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

(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 plan requires prior authorization from the plan’s utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient’s attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient’s attending provider and approved by the plan.

(ii) Conclusion. In this Example 1, the plan violates the rules of this paragraph (c)(4) because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits rather than is applied to medical/surgical benefits.
Example 2. (i) Facts. A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding medical benefits). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorders, but only 30 percent of medical/surgical conditions.

(ii) Conclusion. In this Example 2, the plan complies with the rules of this paragraph (c)(4) because the evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Example 3. (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 and uses comparable criteria in determining whether a course of treatment is medically necessary. 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 3, 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, it is not applied in a comparable way. The penalty for failure to obtain prior approval for the mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 4. (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 is based on clinically appropriate standards of care for that condition.

(ii) Conclusion. In this Example 4, the plan complies with the rules of this paragraph (c)(4) because the processes for developing the evidentiary standards used to determine medical appropriateness and the application of these standards 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 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 5. (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 5, the plan violates the rules of this paragraph (c)(4). Although the standard for applying a nonquantitative treatment limitation is the same for both mental health and substance use disorder benefits and medical/surgical benefits—whether a drug has a black box warning—it is not applied in a comparable manner. 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 6. (i) Facts. An employer maintains both a major medical plan 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 plan 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 plan.

(ii) Conclusion. In this Example 6, 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.

Example 7. (i) Facts. Training and State licensing requirements often vary among types of providers. A plan applies a general standard that any provider must meet the
highly licensing requirement related to supervised clinical experience under applicable State law in order to participate in the plan’s provider network. Therefore, the plan requires that master’s-level mental health therapists to have post-degree, supervised clinical experience but does not impose this requirement on master’s-level general medical providers. Under the plan, the experience under applicable State law does require clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or Ph.D. level psychologists since their licensing already requires supervised training.

(ii) Conclusion. In this Example 7, the plan complies with the rules of this paragraph (c)(4). The requirement that master’s-level mental health therapists must have supervised clinical experience to join the network is permissible, as long as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers.

Example 8. (i) Facts. A plan considers a wide array of factors in designing medical management techniques for both mental health and substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, the plan requires prior authorization for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented by the plan.

(ii) Conclusion. In this Example 8, the plan complies with the rules of this paragraph (c)(4). Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.

Example 9. (i) Facts. A plan generally covers medically appropriate treatments. The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions (including freestanding or residential treatment centers prescribed for mental health conditions, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) Conclusion. In this Example 9, 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 substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

Example 10. (i) Facts. A plan generally provides coverage for medically appropriate medical/surgical benefits as well as mental health and substance use disorder benefits. The plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for medical/surgical benefits within the same classification.

(ii) Conclusion. In this Example 10, the plan violates the rules of this paragraph (c)(4). The plan is imposing a nonquantitative treatment limitation that restricts benefits based on geographic location. Because there is no comparable exclusion that applies to medical/surgical benefits, this exclusion may not be applied to mental health or substance use disorder benefits.

Example 11. (i) Facts. A plan requires prior authorization for all outpatient mental health and substance use disorder services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient medical/surgical benefits, the plan allows an initial visit without prior authorization. After the initial visit, the plan pre-approves benefits based on the individual treatment plan recommended by the attending provider based on that individual’s specific medical condition. There is no explicit, predetermined cap on the
amount of additional visits approved per authorization.

(ii) Conclusion. In this Example 11, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—prior authorization to determine medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits for outpatient services, it is not applied in a comparable way. While the plan is more generous with respect to the number of visits initially provided without pre-authorization for mental health benefits, treating all mental health conditions and substance use disorders in the same manner, while providing for individualized treatment of medical conditions, is not a comparable application of this nonquantitative treatment limitation.

(5) Exemptions. The rules of this paragraph (c) do not apply if a group health plan (or health insurance coverage) 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 (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.

(2) Reason for any denial. The reason for any denial under a group health plan (or health insurance coverage offered in connection with such 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 (or the health insurance issuer offering such coverage) to the participant or beneficiary in a form and manner consistent with the requirements of §2560.503–1 of this chapter for group health plans.

(3) Provisions of other law. Compliance with the disclosure requirements in paragraphs (d)(1) and (d)(2) of this section is not determinative of compliance with any other provision of applicable Federal or State law. In particular, in addition to those disclosure requirements, provisions of other applicable law require disclosure of information relevant to medical/surgical, mental health, and substance use disorder benefits. For example, ERISA section 104 and §2520.104b–1 of this chapter provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, §§2560.503–1 and 2590.715–2719 of this chapter set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant’s claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

(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 medical 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 medical care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) Health insurance issuers. The requirements of this section apply to a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits in connection with a group health plan subject to paragraph (e)(1) of this section.

(3) Scope. This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan (or health insurance coverage) for one or more mental health conditions or substance use disorders does not require the plan or health insurance coverage under this section to provide benefits for any other mental health condition or substance use disorder;

(ii) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits or substance use disorder benefits only to the extent required under PHS Act section 2713 to provide additional mental health or substance use disorder benefits in any classification in accordance with this section; or

(iii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan (or health insurance coverage) except as specifically provided in paragraphs (b) and (c) of this section.

(4) Coordination with EHB requirements. Nothing in paragraph (f) or (g) of this section changes the requirements of 45 CFR 147.150 and 45 CFR 156.115, providing that a health insurance issuer offering non-grandfathered health insurance coverage in the individual or small group market providing mental health and substance use disorder services, including behavioral health treatment services, as part of essential health benefits required under 45 CFR 156.110(a)(5) and 156.115(a), must comply with the provisions of 45 CFR 146.136 to satisfy the requirement to provide essential health benefits.

(f) Small employer exemption—(1) In general. The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (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 732(a) of ERISA and §2590.732(b), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) Rules in determining employer size. For purposes of paragraph (f)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Code 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—(1) In general. If the application of this section to a group health plan (or health insurance coverage offered in connection with such plans) results in an increase for the plan year involved of the actual total cost of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits as determined and certified under paragraph (g)(3) of this section by an amount that exceeds the applicable percentage described in paragraph (g)(2) of this section of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for one plan year. An employer or issuer may elect to continue to provide mental health and substance use disorder benefits in compliance with this section with respect to the plan or coverage involved regardless of any increase in total costs.

(2) Applicable percentage. With respect to a plan or coverage, the applicable percentage described in this paragraph (g) is—

(i) 2 percent in the case of the first plan year in which this section is applied to the plan or coverage; and

(ii) 1 percent in the case of each subsequent plan year.

(3) Determinations by actuaries—(1) Determinations as to increases in actual costs under a plan or coverage that are attributable to implementation of the requirements of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations must be based on the formula specified in paragraph (g)(4) of this section and shall be in a written report prepared by the actuary.

(ii) The written report described in paragraph (g)(3)(i) of this section shall be maintained by the group health plan or health insurance issuer, along with all supporting documentation relied upon by the actuary, for a period of at least six years following the notification made under paragraph (g)(6) of this section.

(4) Formula. The formula to be used to make the determination under paragraph (g)(3)(i) of this section is expressed mathematically as follows:

\[ \left( \frac{E_1 - E_0}{T_0} \right) - D > k \]

(i) \( E_1 \) is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the base period, including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits consistent with the requirements of this section.

(ii) \( E_0 \) is the actual total cost of coverage with respect to mental health and substance use disorder benefits for the length of time immediately before the base period (and that is equal in length to the base period), including claims paid by the plan or issuer with respect to mental health and substance use disorder benefits and administrative costs (amortized over time) attributable to providing these benefits.

(iii) \( T_0 \) is the actual total cost of coverage with respect to all benefits during the base period.

(iv) \( k \) is the applicable percentage of increased cost specified in paragraph (g)(2) of this section that will be expressed as a fraction for purposes of this formula.

(v) \( D \) is the average change in spending that is calculated by applying the formula \( \left( \frac{E_1 - E_0}{T_0} \right) \) to mental health and substance use disorder spending in each of the five prior years and then calculating the average change in spending.

(5) Six month determination. If a group health plan or health insurance issuer seeks an exemption under this paragraph (g), determinations under paragraph (g)(3) of this section shall be made after such plan or coverage has complied with this section for at least the first 6 months of the plan year involved.

(6) Notification. A group health plan or health insurance issuer that, based on the certification described under
paragraph (g)(3) of this section, qualifies for an exemption under this paragraph (g), and elects to implement the exemption, must notify participants and beneficiaries covered under the plan, the Secretary, and the appropriate State agencies of such election.

(i) Participants and beneficiaries—(A) Content of notice. The notice to participants and beneficiaries must include the following information:

(1) A statement that the plan or issuer is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan or issuer name and plan number (PN).

(4) The plan administrator’s name, address, and telephone number.

(5) For single-employer plans, the plan sponsor’s name, address, and telephone number (if different from paragraph (g)(6)(i)(A)(3) of this section) and the plan sponsor’s employer identification number (EIN).

(6) The effective date of such exemption.

(7) A statement regarding the ability of participants and beneficiaries to contact the plan administrator or health insurance issuer to see how benefits may be affected as a result of the plan’s or issuer’s election of the exemption.

(8) A statement regarding the availability, upon request and free of charge, of a summary of the information on which the exemption was based.

(ii) Federal agencies—(A) Content of notice. The notice to the Secretary must include the following information:

(C) Delivery. The notice described in this paragraph (g)(6)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) and its implementing regulations (for example, first-class mail). If the notice is provided to the participant and any beneficiaries at the participant’s last known address, then the requirements of this paragraph (g)(6)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary’s last known address is different from the participant’s last known address, a separate notice is required to be provided to the beneficiary at the beneficiary’s last known address.

(D) Availability of documentation. The plan or issuer must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. (For purposes of this paragraph (g), an individual who is not a participant or beneficiary and who presents a notice described in paragraph (g)(6)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (g)(6)(i) of this section with any personally identifiable information redacted.) The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan or coverage absent amendments required to comply with paragraphs (b) and (c) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any personally identifiable information.

(ii) Federal agencies—(A) Content of notice. The notice to the Secretary must include the following information:
(1) A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost exemption under this paragraph (g) by such plan (or coverage);

(2) For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical/surgical benefits and mental health and substance use disorder benefits; and

(3) For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

(B) Reporting. A group health plan, and any health insurance coverage offered in connection with a group health plan, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (g)(6)(ii)(A) of this section identifying the benefit package to which the exemption applies.

(iii) Confidentiality. A notification to the Secretary under this paragraph (g)(6) shall be confidential. The Secretary shall make available, upon request and not more than on an annual basis, an anonymous itemization of each notification that includes—

(A) A breakdown of States by the size and type of employers submitting such notification; and

(B) A summary of the data received under paragraph (g)(6)(ii) of this section.

(iv) Audits. The Secretary may audit the books and records of a group health plan or a health insurance issuer relating to an exemption, including any actuarial reports, during the 6 year period following notification of such exemption under paragraph (g)(6) of this section. A State agency receiving a notification under paragraph (g)(6) of this section may also conduct such an audit with respect to an exemption covered by such notification.

(b) Sale of nonparity health insurance coverage. A health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from the requirements of this section because the plan meets the requirements of paragraph (f) or (g) of this section.

(1) Applicability dates—(1) In general. Except as provided in paragraph (i)(2) of this section, this section applies to group health plans and health insurance issuers offering group health insurance coverage on the first day of the first plan year beginning on or after July 1, 2014. Until the applicability date, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR 2590.712 contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2013.

(ii) 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 (or health insurance coverage offered in connection with the plan) for plan years beginning before the date on which the last of the collective bargaining agreements terminates (determined without regard to any extension agreed to after October 3, 2008).

[78 FR 68276, Nov. 13, 2013]

§ 2590.715–1251 Preservation of right to maintain existing coverage.

(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)(i) 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 Web site 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 meet 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 meet 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 ERISA section 715 and Internal Revenue Code section 9815) 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 PHS Act, ERISA, and the Internal Revenue Code 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) of the Internal Revenue Code) 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 ERISA section 715 and Internal Revenue Code section 9815) 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.

(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 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).

(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 §2590.702(d) of this part) 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 section 2590.702(d) of this part) by more than 5 percentage points 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 imposes 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
§ 2590.715–1251

29 CFR Ch. XXV (7–1–15 Edition)

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 604 of ERISA, section 4980B(f)(4) of the Internal Revenue Code, 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
Employee Benefits Security Admin., Labor

§ 2590.715–1251

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.

(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 27.858; 27.858 + 30 = 57.858 ($30 × 0.27858 = $8.354). The $30 increase in copayment in this Example 3, 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 $50.

Example 4. (i) Facts. Same facts as Example 3, except on March 23, 2010, the grandfathered health plan has a copayment requirement to $50 for a later plan year. With-in 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% + 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 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% + 15% = 40.27%), or $6.26 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26).

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.

(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 0.2527 (415.0 − 387.142 = 27.858; 27.858 + 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 33.33% (0.2527 × 22.20% + 15% = 33.33%), or $5.36 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26). Because 50% exceeds 33.33% and $15 exceeds $5.36, the change in the copayment requirement that would cause the 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 33.33% (0.2527 × 22.20% + 15% = 33.33%), or $5.36 ($5 × 0.2527 = $1.26; $1.26 + $5 = $6.26).

Example 6. (i) Facts. The same facts as Example 3, 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 pursuant to paragraph (g)(1)(iv) of this section, which would permit an increase in the copayment of up to $5.36.

Example 7. (i) Facts. On March 23, 2010, a self-insured group health plan provides two warranties. The total cost of coverage related to the warranties would cause the plan to cease to be a grandfathered health plan.
§ 2590.715–2704 Prohibition of pre-existing condition exclusions.

(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 § 2590.701–2 of this part).

(2) Examples. The rules of this paragraph (a) are illustrated by the following examples (for additional examples illustrating the definition of a pre-existing condition exclusion, see § 2590.711–3(a)(1)(ii) of this part):

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) Applicability—(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 § 2590.715–1251 of this part 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.

[75 FR 37229, June 28, 2010]

§ 2590.715–2705 Prohibiting discrimination against participants and beneficiaries based on a health factor.

(a) In general. A group health plan and a health insurance issuer offering group health insurance coverage must comply with the requirements of § 2590.702 of this part.

(b) Applicability date. This section is applicable to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after January 1, 2014.

[78 FR 33186, June 3, 2013]

§ 2590.715–2708 Prohibition on waiting periods that exceed 90 days.

(a) General rule. A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days, in accordance with the rules of this section. If, under the terms of a plan, an individual can elect coverage that would begin on a date that is not later than the end of the 90-day waiting period, this paragraph (a) is considered satisfied. Accordingly, in that case, a plan or issuer will not be considered to have violated this paragraph (a) solely because individuals take, or are permitted to take, additional time (beyond the end of the 90-day waiting period) to elect coverage.

(b) Waiting period defined. For purposes of this part, a waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an individual enrolls as a late enrollee (as defined under § 2590.701–2) or special enrollee (as described in § 2590.701–6), any period before such late or special enrollment is not a waiting period.

(c) Relation to a plan’s eligibility criteria—(1) In general. Except as provided in paragraphs (c)(2) and (c)(3) of this section, being otherwise eligible to enroll under the terms of a group health plan means having met the plan’s substantive eligibility conditions (such as, for example, being in an eligible job classification, achieving job-related licensure requirements specified in the plan’s terms, or satisfying a reasonable and bona fide employment-based orientation period). Moreover, except as provided in paragraphs (c)(2) and (c)(3) of this section, nothing in this section requires a plan sponsor to offer coverage to any particular individual or class of individuals (including, for example, part-time employees). Instead, this section prohibits requiring otherwise eligible individuals to wait more than 90 days before coverage is effective. See also section 4980H of the Code and its implementing regulations for an applicable large employer’s shared responsibility to provide health coverage to full-time employees.

(2) Eligibility conditions based solely on the lapse of time. Eligibility conditions that are based solely on the lapse of a time period are permissible for no more than 90 days.

(3) Other conditions for eligibility. Other conditions for eligibility under the terms of a group health plan are generally permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation, determined in accordance with the rules of this paragraph (c)(3).
§ 2590.715–2708  

(1) Application to variable-hour employees in cases in which a specified number of hours of service per period is a plan eligibility condition. If a group health plan conditions eligibility on an employee regularly having a specified number of hours of service per period (or working full-time), and it cannot be determined that a newly-hired employee is reasonably expected to regularly work that number of hours per period (or work full-time), the plan may take a reasonable period of time, not to exceed 12 months and beginning on any date between the employee’s start date and the first day of the first calendar month following the employee’s start date, to determine whether the employee meets the plan’s eligibility condition. Except in cases in which a waiting period that exceeds 90 days is imposed in addition to a measurement period, the time period for determining whether such an employee meets the plan’s eligibility condition will not be considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee’s start date plus, if the employee’s start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

(ii) Cumulative service requirements. If a group health plan or health insurance issuer conditions eligibility on an employee’s having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if coverage is made effective no later than 13 months from the employee’s start date plus, if the employee’s start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month.

(iii) Limitation on orientation periods. To ensure that an orientation period is not used as a subterfuge for the passage of time, or designed to avoid compliance with the 90-day waiting period limitation, an orientation period is permitted only if it does not exceed one month. For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee’s start date in a position that is otherwise eligible for coverage. For example, if an employee’s start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2. Similarly, if an employee’s start date in an otherwise eligible position is October 1, the last permitted day of the orientation period is October 31.

(d) Application to rehires. A plan or issuer may treat an employee whose employment has terminated and who then is rehired as newly eligible upon rehire and, therefore, required to meet the plan’s eligibility criteria and waiting period anew, if reasonable under the circumstances (for example, the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation).

(e) Counting days. Under this section, all calendar days are counted beginning on the enrollment date (as defined in § 2590.701–2), including weekends and holidays. A plan or issuer that imposes a 90-day waiting period may, for administrative convenience, choose to permit coverage to become effective earlier than the 91st day if the 91st day is a weekend or holiday.

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

Example 1. (i) Facts. A group health plan provides that full-time employees are eligible for coverage under the plan. Employee A begins employment as a full-time employee on January 19.

(ii) Conclusion. In this Example 1, any waiting period for A would begin on January 19 and may not exceed 90 days. Coverage under the plan must become effective no later than April 19 (assuming February lasts 28 days).

Example 2. (i) Facts. A group health plan provides that only employees with job title M are eligible for coverage under the plan. Employee B begins employment with job title L on January 30.

(ii) Conclusion. In this Example 2, B is not eligible for coverage under the plan, and the period while B is working with job title L

894
and therefore not in an eligible class of employees, is not part of a waiting period under this section.

Example 3. (i) Facts. Same facts as in Example 2. C transfers to a new position with job title M on April 11.

(ii) Conclusion. In this Example 3, B becomes eligible for coverage on April 11, but for the waiting period. Any waiting period for B begins on April 11 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than July 10.

Example 4. (i) Facts. A group health plan provides that only employees who have completed specified training and achieved specified certifications are eligible for coverage under the plan. Employee C is hired on May 3 and meets the plan’s eligibility criteria on September 22.

(ii) Conclusion. In this Example 4, C becomes eligible for coverage on September 22, but for the waiting period. Any waiting period for C would begin on September 22 and may not exceed 90 days; therefore, coverage under the plan must become effective no later than December 21.

Example 5. (i) Facts. A group health plan provides that employees are eligible for coverage after one year of service.

(ii) Conclusion. In this Example 5, the plan’s eligibility condition is based solely on the lapse of time and, therefore, is impermissible under paragraph (c)(2) of this section because it exceeds 90 days.

Example 6. (i) Facts. Employer V’s group health plan provides for coverage to begin on the first day of the first payroll period on or after the date an employee is hired and completes the applicable enrollment forms. Enrollment forms are distributed on an employee’s start date and may be completed within 90 days. Employee D is hired and starts on October 31, which is the first day of a pay period. D completes the enrollment forms and submits them on the 90th day after D’s start date, which is January 28. Coverage is made effective 7 days later, February 4, which is the first day of the next pay period.

(ii) Conclusion. In this Example 6, under the terms of V’s plan, coverage may become effective as early as October 31, depending on when D completes the applicable enrollment forms. Under the terms of the plan, when coverage becomes effective depends solely on the length of time taken by D to complete the enrollment materials. Therefore, under the terms of the plan, D may elect coverage that would begin on a date that does not exceed the 90-day waiting period limitation, and the plan complies with this section.

Example 7. (i) Facts. Under Employer W’s group health plan, only employees who are full-time (defined under the plan as regularly averaging 30 hours of service per week) are eligible for coverage. Employee E begins employment for Employer W on November 26 of Year 1. E’s hours are reasonably expected to vary, with an opportunity to work between 20 and 45 hours per week, depending on shift availability and E’s availability. Therefore, it cannot be determined at E’s start date that E is reasonably expected to work full-time. Under the terms of the plan, variable-hour employees, such as E, are eligible to enroll in the plan if they are determined to be a full-time employee under the terms of the plan, coverage becomes effective no later than the first day of the first calendar month after the applicable enrollment forms are received. E’s 12-month measurement period ends November 25 of Year 2. E is determined to be a full-time employee and is notified of E’s plan eligibility. If E then elects coverage, E’s first day of coverage will be January 1 of Year 3.

(ii) Conclusion. In this Example 7, the measurement period is permissible because it is not considered to be designed to avoid compliance with the 90-day waiting period limitation. The plan may use a reasonable period of time to determine whether a variable-hour employee is a full-time employee, provided that (a) the period of time is no longer than 12 months; (b) the period of time begins on a date between the employee’s start date and the first day of the next calendar month (inclusive); (c) coverage is made effective no later than 13 months from E’s start date plus, if the employee’s start date is not the first day of a calendar month, the time remaining until the first day of the next calendar month; and (d) in addition to the measurement period, no more than 90 days elapse prior to the employee’s eligibility for coverage.

Example 8. (i) Facts. Employee F begins working 25 hours per week for Employer X on January 6 and is considered a part-time employee for purposes of X’s group health plan. X sponsors a group health plan that provides coverage to part-time employees after they have completed a cumulative 1,200 hours of service. F satisfies the plan’s cumulative hours of service condition on December 15.

(ii) Conclusion. In this Example 8, the cumulative hours of service condition with respect to part-time employees is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, coverage for F under the plan must begin no later than the 91st day after F completes 1,200 hours. (If the plan’s cumulative hours-of-service requirement was more than 1,200 hours, the requirement would be considered to be designed to avoid compliance with the 90-day waiting period limitation.)

Example 9. (i) Facts. A multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working a specified number of hours of covered employment for
multiple contributing employers. The plan aggregates hours in a calendar quarter and then, if enough hours are earned, coverage begins the first day of the next calendar quarter. The plan also permits coverage to extend for the next full calendar quarter, regardless of whether an employee’s employment has terminated.

(ii) Conclusion. In this Example 9, these eligibility provisions are designed to accommodate a unique operating structure, and, therefore, are not considered to be designed to avoid compliance with the 90-day waiting period limitation, and the plan complies with this section.

Example 10. (i) Facts. Employee G retires at age 55 after 30 years of employment with Employer Y with no expectation of providing further services to Employer Y. Three months later, Y recruits G to return to work as an employee providing advice and transition assistance for G’s replacement under a one-year employment contract. Y’s plan imposes a 90-day waiting period from an employee’s start date before coverage becomes effective.

(ii) Conclusion. In this Example 10, Y’s plan may treat G as newly eligible for coverage under the plan upon rehire and therefore may impose the 90-day waiting period with respect to G for coverage offered in connection with G’s rehire.

Example 11. (i) Facts. Employee H begins working full time for Employer Z on October 16. Z sponsors a group health plan, under which full time employees are eligible for coverage after they have successfully completed a bona fide one-month orientation period. H completes the orientation period on November 15.

(ii) Conclusion. In this Example 11, the orientation period is not considered a subterfuge for the passage of time and is not considered to be designed to avoid compliance with the 90-day waiting period limitation. Accordingly, plan coverage for H must begin no later than December 16, which is the 91st day after H completes the orientation period. (If the orientation period was longer than one month, it would be considered to be a subterfuge for the passage of time and designed to avoid compliance with the 90-day waiting period limitation. Accordingly it would violate the rules of this section.)

(g) Special rule for health insurance issuers. To the extent coverage under a group health plan is insured by a health insurance issuer, the issuer is permitted to rely on the eligibility information reported to it by the employer (or other plan sponsor) and will not be considered to violate the requirements of this section with respect to its administration of any waiting period, if both of the following conditions are satisfied:

(1) The issuer requires the plan sponsor to make a representation regarding the terms of any eligibility conditions or waiting periods imposed by the plan sponsor before an individual is eligible to become covered under the terms of the plan (and requires the plan sponsor to update this representation with any changes), and

(2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.

(b) No effect on other laws. Compliance with this section is not determinative of compliance with any other provision of State or Federal law (including ERISA, the Code, or other provisions of the Patient Protection and Affordable Care Act). See e.g., §2590.702, which prohibits discrimination in eligibility for coverage based on a health factor and Code section 4980H, which generally requires applicable large employers to offer coverage to full-time employees and their dependents or make an assessable payment.

(1) Applicability date. The provisions of this section apply for plan years beginning on or after January 1, 2015. See §2590.715-1251 providing that the prohibition on waiting periods exceeding 90 days applies to all group health plans and group health insurance issuers, including grandfathered health plans.


§2590.715-2711 No lifetime or annual limits.

(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—(1) 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) of the Internal Revenue Code) 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 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—(1) 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 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 §2590.701–6(d) of this part. 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 §2590.715–1251(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) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See §2590.715–1251 of this Part 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).

[75 FR 37229, June 28, 2010]

§ 2590.715–2712 Rules regarding rescissions.

(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 section. The con- testability period that may otherwise apply.

(2) For purposes of this section, a rescission is a cancellation or discontinu- ance 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 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 pre- miums or contributions towards the cost of coverage.

(b) 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

Example 2. (i) Facts. Individual B seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage

Example 3. (i) Facts. Individual C seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage

Example 4. (i) Facts. Individual D 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.

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 reassigned 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 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 reassigned 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) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See §2590.715–1251 of this part 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).

[75 FR 37231, June 28, 2010]
(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.

(ii) **Conclusion.** In this **Example 1,** the plan may impose a cost-sharing requirement for the office visit.

**Example 2.** (i) **Facts.** Same facts as Example 1.

(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) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See §2590.715–1251 of this Part 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).


§ 2590.715–2713A Accommodations in connection with coverage of preventive health services.

(a) Eligible organizations. An eligible organization is an organization that satisfies all of the following requirements:

(1) The organization opposes providing coverage for some or all of any contraceptive services required to be covered under §2590.715–2713(a)(1)(iv) on account of religious objections.

(2) The organization is organized and operates as a nonprofit entity.

(3) The organization holds itself out as a religious organization.

(4) The organization self-certifies, in a form and manner specified by the Secretary, that it satisfies the criteria in paragraphs (a)(1) through (3) of this section, and makes such self-certification available for examination upon request by the first day of the first plan year to which the accommodation in paragraph (b) or (c) of this section applies. The self-certification must be executed by a person authorized to make the certification on behalf of the organization, and must be maintained in a manner consistent with the record retention requirements under section 107 of ERISA.

(b) Contraceptive coverage—self-insured group health plans—(1) A group health plan established or maintained by an eligible organization that provides benefits on a self-insured basis complies for one or more plan years with any requirement under §2590.715–2713(a)(1)(iv) to provide contraceptive coverage if all of the requirements of this paragraph (b)(1) are satisfied:

(i) The eligible organization or its plan contracts with one or more third party administrators.

(ii) The eligible organization provides a copy of the self-certification to each third party administrator.
organization and of its religious objection to coverage of all or a subset of contraceptive services.

(A) When a copy of the self-certification is provided directly to a third party administrator, such self-certification must include notice that obligations of the third party administrator are set forth in §2510.3–16 of this chapter and this section.

(B) When a notice is provided to the Secretary of Health and Human Services, the notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on sincerely held religious beliefs to coverage of some or all contraceptive services (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (i.e., whether it is a student health insurance plan within the meaning of 45 CFR 147.145(a) or a church plan within the meaning of ERISA section 3(33)); and the name and contact information for any of the plan’s third party administrators and health insurance issuers. If there is a change in any of the information required to be included in the notice, the organization must provide updated information to the Secretary of Health and Human Services. The Department of Labor (working with the Department of Health and Human Services) shall send a separate notification to each of the plan’s third party administrators informing the third party administrator that the Secretary of Health and Human Services has received a notice under paragraph (b)(1)(ii) of this section and describing the obligations of the third party administrator under §2510.3–16 of this chapter and this section.

(2) If a third party administrator receives a copy of the self-certification from an eligible organization or a notification from the Department of Labor, as described in paragraph (b)(1)(ii) of this section, and agrees to enter into or remain in a contractual relationship with the eligible organization or its plan to provide administrative services for the plan, the third party administrator shall provide or arrange payments for contraceptive services using one of the following methods—

(i) Provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries; or

(ii) Arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.

(3) If a third party administrator provides or arranges payments for contraceptive services in accordance with either paragraph (b)(2)(i) or (ii) of this section, the costs of providing or arranging such payments may be reimbursed through an adjustment to the Federally-facilitated Exchange user fee for a participating issuer pursuant to 45 CFR 156.50(d).

(4) A third party administrator may not require any documentation other than a copy of the self-certification from the eligible organization or notification from the Department of Labor described in paragraph (b)(1)(ii) of this section.

(c) Contraceptive coverage—insured group health plans—(1) General rule. A group health plan established or maintained by an eligible organization that provides benefits through one or more group health insurance issuers complies for one or more plan years with any requirement under §2590.715–2713(a)(1)(iv) to provide contraceptive coverage if the eligible organization or entity to provide payments for contraceptive services for the plan, the third party administrator agrees to enter into or remain in a contractual relationship with the eligible organization or its plan to provide administrative services for the plan, the third party administrator shall provide or arrange payments for contraceptive services using one of the following methods—

(i) Provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries; or

(ii) Arrange for an issuer or other entity to provide payments for contraceptive services for plan participants and beneficiaries without imposing any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or imposing a premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries.
(i) When a copy of the self-certification is provided directly to an issuer, the issuer has sole responsibility for providing such coverage in accordance with §2590.715–2713. An issuer may not require any further documentation from the eligible organization regarding its status as such.

(ii) When a notice is provided to the Secretary of Health and Human Services, the notice must include the name of the eligible organization and the basis on which it qualifies for an accommodation; its objection based on its sincerely held religious beliefs to coverage of some or all contraceptive services, as applicable (including an identification of the subset of contraceptive services to which coverage the eligible organization objects, if applicable); the plan name and type (i.e., whether it is a student health insurance plan within the meaning of 45 CFR 147.145(a) or a church plan within the meaning of ERISA section 3(33)); and the name and contact information for any of the plan’s third party administrators and health insurance issuers. If there is a change in any of the information required to be included in the notice, the organization must provide updated information to the Secretary of Health and Human Services. The Department of Health and Human Services will send a separate notification to each of the plan’s health insurance issuers informing the issuer that the Secretary of Health and Human Services has received a notice under paragraph (c)(1) of this section and describing the obligations of the issuer under this section.

(2) Payments for contraceptive services—(i) A group health insurance issuer that receives a copy of the self-certification or notification described in paragraph (c)(1)(ii) of this section with respect to a group health plan established or maintained by an eligible organization in connection with which the issuer would otherwise provide contraceptive coverage under §2590.715–2713(a)(1)(iv) must—

(A) Expressly exclude contraceptive coverage from the group health insurance coverage provided in connection with the group health plan; and

(B) Provide separate payments for any contraceptive services required to be covered under §2590.715–2713(a)(1)(iv) for plan participants and beneficiaries for so long as they remain enrolled in the plan.

(ii) With respect to payments for contraceptive services, the issuer may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible), or impose any premium, fee, or other charge, or any portion thereof, directly or indirectly, on the eligible organization, the group health plan, or plan participants or beneficiaries. The issuer must segregate premium revenue collected from the eligible organization from the monies used to provide payments for contraceptive services. The issuer must provide payments for contraceptive services in a manner that is consistent with the requirements under sections 2706, 2709, 2711, 2713, 2719, and 2719A of the PHS Act, as incorporated into section 715 of ERISA. If the group health plan of the eligible organization provides coverage for some but not all of any contraceptive services required to be covered under §2590.715–2713(a)(1)(iv), the issuer is required to provide payments only for those contraceptive services for which the group health plan does not provide coverage. However, the issuer may provide payments for all contraceptive services, at the issuer’s option.

(d) Notice of availability of separate payments for contraceptive services—self-insured and insured group health plans. For each plan year to which the accommodation in paragraph (b) or (c) of this section is to apply, a third party administrator required to provide or arrange payments for contraceptive services pursuant to paragraph (b) of this section, and an issuer required to provide payments for contraceptive services pursuant to paragraph (c) of this section, must provide to plan participants and beneficiaries written notice of the availability of separate payments for contraceptive services contemporaneous with (to the extent possible), but separate from, any application materials distributed in connection with enrollment (or re-enrollment) in group health coverage that is effective beginning on the first day of each applicable plan year. The notice
must specify that the eligible organization does not administer or fund contraceptive benefits, but that the third party administrator or issuer, as applicable, provides separate payments for contraceptive services, and must provide contact information for questions and complaints. The following model language, or substantially similar language, may be used to satisfy the notice requirement of this paragraph (d):

"Your employer has certified that your group health plan qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your employer will not contract, arrange, pay, or refer for contraceptive coverage. Instead, [name of third party administrator/health insurance issuer] will provide or arrange separate payments for contraceptive services that you use, without cost sharing and at no other cost, for so long as you are enrolled in your group health plan. Your employer will not administer or fund these payments. If you have any questions about this notice, contact [contact information for third party administrator/health insurance issuer]."

(e) Reliance—insured group health plans—(1) If an issuer relies reasonably and in good faith on a representation by the eligible organization as to its eligibility for the accommodation in paragraph (c) of this section, and the representation is later determined to be incorrect, the issuer is considered to comply with any requirement under §2590.715–2713(a)(1)(iv) to provide contraceptive coverage if the issuer complies with the obligations under this section applicable to such issuer.

(2) A group health plan is considered to comply with any requirement under §2590.715–2713(a)(1)(iv) to provide contraceptive coverage if the plan complies with its obligations under paragraph (c) of this section, without regard to whether the issuer complies with the obligations under this section applicable to such issuer.

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 the 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 §2590.701–6(d) of this Part. 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 because the child is 22.

(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) of the Internal Revenue Code) 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.
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 §2590.715–1251 of this Part for determining the application of this section to grandfathered health plans.

[75 FR 27136, May 13, 2010, as amended at 75 FR 34566, June 17, 2010]

§ 2590.715–2715 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 to 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 the 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 the 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 §2590.701–6 of
this Part) no later than the date by which a summary plan description is required to be provided under the time-frame 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.

(ii) 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 accord-ance 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;
statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) of the Internal Revenue Code 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;

(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 §2590.715–2719(e) of this Part 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 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. See §2590.731 of this part. In addition, 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 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) Applicability date—(1) This section is applicable to group health plans and group health insurance issuers in accordance with this paragraph (f). (See §2590.175–1251(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.

[77 FR 8700, Feb. 14, 2012]

EFFECTIVE DATE NOTE: At 80 FR 34307, June 16, 2015, §2590.715–2715 was revised, effective Aug. 17, 2015. For the convenience of the user, the revised text is set forth as follows:

§2590.715–2715 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. If an SBC was provided before application pursuant to paragraph (a)(1)(i)(A) of this section (relating to SBCs upon request), this paragraph (a)(1)(i)(A) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information required, a new SBC that includes the changed information must be provided upon application pursuant to this paragraph (a)(1)(i)(A).

(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, reissuance, or reenrollment. If the issuer renews or reissues a policy, certificate, or contract of insurance for a succeeding policy year, or automatically re-enrolls the policyholder or its participants and beneficiaries in coverage, the issuer must provide a new SBC as follows:

(I) 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.

(II) If renewal, reissuance, or reenrollment 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 issuing 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 the rules of paragraph (a)(1)(ii) 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 provided no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries. If an SBC was provided before application pursuant to paragraph (a)(1)(ii)(F) of this section (relating to SBCs upon request), this paragraph (a)(1)(ii)(B) is deemed satisfied, provided there is no change to the information required to be in the SBC. However, if there has been a change in the information that is required to be in the SBC, a new SBC that includes the changed information must be provided upon application pursuant to this paragraph (a)(1)(ii)(B).

(C) By first day of coverage (if there are changes). (1) 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.

(2) If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan or issuer is not required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage.

(Special enrollees. The plan or issuer must provide the SBC to special enrollees (as described in §2590.701-6) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 194(b)(1)(A) and its implementing regulations, which is 90 days from enrollment.

(E) Upon renewal, reissuance, or reenrollment. If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), or automatically re-enrolls participants and beneficiaries in coverage, the plan or issuer must provide a new SBC, as follows:

(1) If written application is required for renewal, reissuance, or reenrollment (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, reissuance, or reenrollment 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. An entity required to provide an SBC under this paragraph (a)(1) with respect to an individual that contracts with another party to provide such SBC is considered to satisfy the requirement to provide such SBC if:

(1) The entity monitors performance under the contract;

(2) If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

(3) If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity
communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

(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 to participants and beneficiaries upon renewal or reenrollment only with respect to the benefit package in which a participant or beneficiary is enrolled (or will be automatically re-enrolled under the plan); SBCs are not required to be provided automatically upon renewal or reenrollment with respect to benefit packages in which the participant or beneficiary is not enrolled (or will not automatically be 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, SBCs (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.

(D) Subject to paragraph (a)(2)(ii) of this section, a plan administrator of a group health plan that uses two or more insurance products provided by separate health insurance issuers with respect to a single group health plan may synthesize the information into a single SBC or provide multiple partial SBCs provided that all the SBC include the content in paragraph (a)(2)(iii) of this section.

(2) Content—(i) In general. Subject to paragraph (a)(2)(ii) 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 the rules of 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 actuarial value 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;

(J) For issuers, an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;

(K) 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;

(L) 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

(M) 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 benefit 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) Benefit scenarios. For purposes of this paragraph (a)(2)(ii), a benefit 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 benefit 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 benefit 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. (i) 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.

(ii) A group health plan that utilizes two or more benefit packages (such as major medical coverage and a health flexible spending arrangement) may synthesize the information into a single SBC, or provide multiple SBCs.

(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 or coverage, the SBC may be provided electronically as described in this paragraph (a)(4)(ii)(A). However, in all cases, the plan or issuer must provide the SBC in paper form if paper form is requested.

(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 response to an online request made by a participant or beneficiary for the SBC.

(C) If 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 §2590.715–2719(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 the rules of 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 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, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, preauthorization, 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. See §2590.731. State laws that conflict with this section (including a state law that requires 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 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). The Department will enforce this section using a process and procedure consistent with §2560.503–1, as well as 29 CFR 2560.502c–2 of this chapter and 29 CFR part 2570, subpart C.

(f) Applicability to Medicare Advantage benefits. The requirements of this section do not apply to a group health plan benefit package that provides Medicare Advantage benefits pursuant to or §29 U.S.C. Chapter 7, Subchapter XVIII, Part C.

(g) Applicability date. (1) This section is applicable to group health plans and health insurance issuers in accordance with this paragraph (g). (See §2590.715–1251(d), providing that this section applies to grandfathered health plans.)

(1) For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including re-enrollees and late enrollees), this section applies beginning on the first day of the first plan year that begins on or after September 1, 2015; 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 1, 2015.

(2) For disclosures with respect to plans, this section is applicable to health insurance issuers beginning September 1, 2015.

§2590.715–2719 Internal claims and appeals and external review processes.

(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 §2590.715–1251 of this part. 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 §2590.715–2712(a)(2) of this part (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.


(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)(i) 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 §2590.715–2712 of this part.)

(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)(i)(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(h)(2)—

(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; 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 (b) 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)(i)(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—(I) 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 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.

(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.
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.

(iv) Examples. This rule 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)(i) 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 effectively be 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)(i) 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 standard 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 decisionmaking, 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, as applicable.

(g) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010. See §2590.715–1251 of this part 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).

(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 participating primary care provider 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 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. 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 beneficiary who seeks coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(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 designates B as the primary care provider for A’s child, B requests that Pediatrician C designates a pediatrician for C’s child A’. C 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 of the terms of the plan or health insurance coverage regarding designation of 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 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—(1) 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 this paragraph (b); 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) Co-payments 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 10%.
(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 rendering 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 $90 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 $90, two have agreed to accept $100, 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 80% 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 in $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 $290 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) Applicability date. The provisions of this section apply for plan years beginning on or after September 23, 2010.

§ 2590.731 Preemption; State flexibility; construction.

(a) Continued applicability of State law with respect to health insurance issuers. Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part 7 of subtitle B of Title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) Continued preemption with respect to group health plans. Nothing in part 7 of subtitle B of Title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) Special rules—(1) In general. Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of Title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 of the Act to the extent that such provision requires special enrollment periods in addition to those required under section 701(f) of the Act.

(d) Definitions—(1) State law. For purposes of this section the term State law includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a
State law rather than a law of the United States.

(2) State. For purposes of this section the term State includes a State (as defined in §2590.701–2), any political subdivisions of a State, or any agency or instrumentality of either.


§2590.732 Special rules relating to group health plans.

(a) Group health plan—(1) Defined. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(b) Determination of number of plans.

(1) Subject to paragraph (b)(2) of this section, the requirements of this part do not apply to any group health plan (and group health insurance coverage) 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 following requirements apply without regard to paragraph (b)(1) of this section:

(i) Section 2590.702(b) of this Part, as such section applies with respect to genetic information as a health factor.

(ii) Section 2590.702(c) of this Part, as such section applies with respect to genetic information as a health factor.

(iii) Section 2590.702(e) of this Part, as such section applies with respect to genetic information as a health factor.

(iv) Section 2590.702–1(b) of this Part.

(v) Section 2590.702–1(c) of this Part.

(vi) Section 2590.702–1(d) of this Part.

(vii) Section 2590.702–1(e) of this Part.

(viii) Section 2590.711 of this Part.

(c) Excepted benefits—(1) In general. The requirements of this Part do not apply to any group health plan (or any group health insurance coverage) 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—(1) 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. Furthermore, benefits provided under an employee assistance program are excepted benefits if they satisfy the requirements of paragraph (c)(3)(vi) 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, a separate plan, or as the only plan offered to participants) if either paragraph (c)(3)(v)(A) or (B) are satisfied.

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.
(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) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) Health flexible spending arrangements. Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) 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).

(vi) Employee assistance programs. Benefits provided under employee assistance programs are excepted if they satisfy all of the requirements of this paragraph (c)(3)(vi).

(A) The program does not provide significant benefits in the nature of medical care. For this purpose, the amount, scope and duration of covered services are taken into account.

(B) The benefits under the employee assistance program are not coordinated with benefits under another group health plan, as follows:

(I) Participants in the other group health plan must not be required to use and exhaust benefits under the employee assistance program (making the employee assistance program a gatekeeper) before an individual is eligible for benefits under the other group health plan; and

(2) Participant eligibility for benefits under the employee assistance program must not be dependent on participation in another group health plan.

(C) No employee premiums or contributions are required as a condition of participation in the employee assistance program.

(D) There is no cost sharing under the employee assistance program.

(vii) Limited wraparound coverage. Limited benefits provided through a group health plan that wrap around eligible individual health insurance (or Basic Health Program coverage described in section 1331 of the Patient Protection and Affordable Care Act); or that wrap around coverage under a Multi-State Plan described in section 1334 of the Patient Protection and Affordable Care Act, collectively referred to as “limited wraparound coverage,” are excepted benefits if all of the following conditions are satisfied. For this purpose, eligible individual health insurance is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and §2590.715-1251), not a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016), and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(A) Covers additional benefits. The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance, Basic Health Program coverage, or Multi-
State Plan coverage. The limited wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement.

(B) Limited in amount. The annual cost of coverage per employee (and any covered dependents, as defined in §2590.701–2) under the limited wraparound coverage does not exceed the greater of the amount determined under either paragraph (c)(3)(vii)(B)(1) or (2) of this section. Making a determination regarding the annual cost of coverage per employee must occur on an aggregate basis relying on sound actuarial principles.

(1) The maximum permitted annual salary reduction contribution toward health flexible spending arrangements, indexed in the manner prescribed under section 125(i)(2) of the Code. For this purpose, the cost of coverage under the limited wraparound includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(2) Fifteen percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage under the limited wraparound coverage includes both employer and employee contributions towards coverage and each is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) Nondiscrimination. All of the conditions of this paragraph (c)(3)(vii)(C) are satisfied.

(1) No preexisting condition exclusion. The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (incorporated by reference into section 715 of ERISA) and §2590.715–2704.

(2) No discrimination based on health status. The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual, as defined in §2590.701–2), consistent with the requirements of section 702 of ERISA and section 2705 of the PHS Act (incorporated by reference into section 715 of ERISA).

(3) No discrimination in favor of highly compensated individuals. Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act (incorporated by reference into section 715 of ERISA) or fails to be excludible from income for any individual due to the application of section 105(h) of the Code (as applicable).

(D) Plan eligibility requirements. Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (c)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (c)(3)(vii)(D)(1) or (2) of this section are met.

(i) Limited wraparound coverage that wraps around eligible individual insurance for persons who are not full-time employees. Coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage) must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(1).

(ii) For each year for which limited wraparound coverage is offered, the employer that is the sponsor of the plan offering limited wraparound coverage, or the employer participating in a plan offering limited wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H–5(e)(2)). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their
coverage offered and affordability information, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. In the event that the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of paragraph (c)(3)(vii)(D)(ii) is considered satisfied.

(ii) Eligibility for the limited wraparound coverage is limited to employees who are reasonably determined at the time of enrollment to be full-time employees (and their dependents, as defined in §2590.701–2), or who are retirees (and their dependents, as defined in §2590.701–2). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the limited wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the limited wraparound coverage.

(2) Limited coverage that wraps around Multi-State Plan coverage. Coverage that wraps around Multi-State Plan coverage must satisfy all of the conditions of paragraph (c)(3)(vii)(D)(ii). For this purpose, the term “full-time employee” means a “full-time employee” as defined in 26 CFR 54.4980H–1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H–1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and contribution levels for 2013 or 2014 (as applicable), and for any year in which limited wraparound coverage is offered, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is reviewed and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section.

(ii) The employer offered coverage in the plan year that began in either 2013 or 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions had been applicable. In the event that a plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(ii) is considered satisfied.

(iii) In the plan year that began in either 2013 or 2014, the employer offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H–5(e)(2)). In the event that the plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(ii) is considered satisfied.

(iv) For the duration of the pilot program, as described in paragraph (c)(3)(vii)(F) of this section, the employer’s annual aggregate contributions for both primary and limited wraparound coverage are substantially
the same as the employer’s total contributions for coverage offered to full-time employees in 2013 or 2014.

(E) Reporting—(1) Reporting by group health plans and group health insurance issuers. A self-insured group health plan, or a health insurance issuer, offering or proposing to offer limited wraparound coverage in connection with Multi-State Plan coverage pursuant to paragraph (c)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

(2) Reporting by group health plan sponsors. The plan sponsor of a group health plan offering limited wraparound coverage under paragraph (c)(3)(vii) of this section, must report to the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) Pilot program with sunset—The provisions of paragraph (c)(3)(vii) of this section apply to limited wraparound coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends no later than on the later of:

(1) The date that is three years after the date limited wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered).

(4) Noncoordinated benefits—(i) Exempted 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 supplementary 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. Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2)) as an employee welfare benefit plan that is a group health plan.

(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]